S. HRG. 107–393

PRESIDENT'S FISCAL YEAR 2002 BUDGET PROPOSAL FOR VA

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

MARCH 13, 2001

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C O N T E N T S

MARCH 13, 2001

SENATORS

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PRESIDENT'S FISCAL YEAR 2002 BUDGET PROPOSAL FOR VA

TUESDAY, MARCH 13, 2001

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 9:35 a.m. in room SR–418, Russell Senate Office Building, Hon. Arlen Specter (chairman of the committee) presiding.

Present: Senators Specter, Thurmond, Campbell, Craig, Hutchinson, Wellstone, Murray, Miller, and Nelson.

Chairman SPECTER. Good morning, ladies and gentlemen.

We will now proceed with the hearing of the Veterans' Affairs Committee.

Senator Rockefeller, our distinguished Ranking Member, will be joining us shortly. His staff advises that he would prefer that we proceed, which we shall do at this time.

We are pleased to have with us this morning the new Secretary of Veterans Affairs, Anthony Principi, and his distinguished staff. We welcome you here again, Mr. Secretary. I personally thank you for attending the session in Philadelphia last week at the Veterans Hospital there, and then you proceeded with Congressman Christopher Smith up to North Jersey, Congressman Smith being the chairman of the Veterans Committee in the House.

We have a very pleasant proceeding at this time, and that is the recognition of the distinguished President pro tempore of the U.S. Senate, a man who has established an extraordinary record. Without further preliminaries, I will ask the Clerk to make a reading at this time.

The CLERK [reading]:

RESOLUTION DESIGNATING THE HONORABLE STROM THURMOND, PRESIDENT PRO TEMPORE OF THE SENATE, AS CHAIRMAN EMERITUS OF THE U.S. SENATE COMMITTEE ON VETERANS' AFFAIRS

Resolved,

Whereas, Senator Strom Thurmond was instrumental in the founding of the Committee on Veterans' Affairs and has served continuously on the Committee since its creation in 1971; and

Whereas, Senator Thurmond has served for forty-seven years in the U.S. Senate, and has served with distinction as Chairman of the Judiciary Committee, Chairman of the Armed Services Committee, and was designated in 1999 as Chairman Emeritus of the Armed Services Committee; and

Whereas, Senator Thurmond has not heretofore served as Chairman of the Committee on Veterans' Affairs despite his status as the senior member of the Committee; and

Whereas, Senator Thurmond was commissioned a 2nd Lieutenant in the United States Army Reserve in 1924 and served in the Army Reserve and on active duty for thirty-six years rising to the rank of Major General; and

Whereas, Senator Thurmond received the Purple Heart for injuries received while participating in the Normandy invasion with the 82d Airborne Division on D-Day, June 6, 1944; and

Whereas, Senator Thurmond, in addition to the Purple Heart, was awarded five Battle Stars for his military service and, in addition, earned eighteen decorations, medals, and ribbons including the Legion of Merit with Oak Leaf Cluster, Bronze Star for Valor, Belgian Order of the Crown and French Croix de Guerre; and

Whereas, Senator Thurmond's leadership and devotion to duty have been dedicated to his fellow veterans through his sponsorship of such legislation as: the Department of Veterans' Affairs Act, establishing the Veterans Administration as an executive department; the Veterans Cemetery Protection Act; and the establishment of the Department of Labor Assistant Secretary for Veterans Employment and Training; and

Whereas, Senator Thurmond has been recognized by the American Legion, the Veterans of Foreign Wars, AMVETS, the Disabled American Veterans, the Paralyzed Veterans of America, and by many other veterans service organizations, for his sincere dedication and enormous contributions to veterans:

Now, therefore, be it

Resolved, that the Honorable Strom Thurmond, President Pro Tempore of the Senate, in recognition of his outstanding and selfless service to America's veterans, is hereby designated Chairman Emeritus of the U.S. Senate Committee on Veterans' Affairs, and he shall hereafter receive the same acknowledgement and recognition as that fitting other Senators who have served as Chairman of this Committee. [Applause.]

Chairman SPECTER. It is too late at this point to call for a vote. [Laughter.]

So, as the lesser chair of the committee, I will determine that the resolution is adopted by acclamation.

Senator Thurmond, would you care to make a comment?

Senator THURMOND. Thank you very much, Mr. Chairman.

Thirty years ago the Senate passed a resolution organizing the committee for the first time. Since that time, I have had the privilege of serving on this committee with many fine men and women. Although the faces have changed over the years, the dedication of the members of this committee has remained constant. I enjoy my service on this committee and the association I have had with those who have served and with each of you who presently serve on this important committee.

I am pleased that Secretary Principi and representatives from the various veterans service organizations are here today. I appreciate their service and the veterans they represent. I know they continue to care about issues we originally faced and which are still areas of concern: compensation and pensions; improving medical care; and veterans education, training, and employment.

I greatly appreciate the honor which this committee has bestowed on me. I express my great appreciation to you, to the other members, and to the staff for this recognition as Chairman Emeritus. Thank you again.

[The prepared statement of Senator Thurmond follows:]

PREPARED STATEMENT OF HON. STROM THURMOND, U.S. SENATOR FROM SOUTH CAROLINA

Mr. Chairman: Thirty years ago, on January 28, 1971, the Senate passed a Resolution organizing this Committee for the first time. On that day five members of the majority party where named as members—Senator Hartke as Chairman, joined by Senators Talmadge, Randolph, Hughes and Cranston. The following day, Janu-

ary 29, the Republican members of the Committee were elected. Joining me were Senators Hansen, Cook and Stevens.

Since that time, I have had the privilege of serving on this Committee with many fine men and women. Although the faces have changed over the years, the dedication of the Members of this Committee have remained constant. I enjoy my service on this Committee and the association I have had with those who have served and with each of you who presently serve on this important Committee.

I reviewed the Congressional Record for the 92nd Congress, that first year of this Committee's existence. The issues which we faced then might seem familiar. Our agenda then including Veterans loans, compensation and pensions, improving medical care, grants for adapted housing for disabled veterans, national service life insurance, establishment of a National Cemetery system, the Health Professions Training Act, and the Veterans Education and Training Assistance Act.

These were not new issues to the Congress. Prior to the establishment of this Committee, however, veterans issues were divided among other Committees of the Senate, including the Labor Committee and Finance Committee. The establishment of this Committee ensured that veterans issues would receive the attention they deserved in a comprehensive manner. I supported the establishment of this committee and continue to be a strong advocate.

Veterans issues have been very important to me. Mr. Chairman, the veterans who are with us today, and those they represent, served with honor and distinction. They fulfilled the highest obligation of American citizenship by defending this country in time of need. Accordingly, our Nation has an equal responsibility to care for these men and women who have sacrificed and suffered as a result of their service. We must continue to work to ensure that the great debt owed to our veterans is honored. They deserve no less. Therefore, as a member of this Committee, I will continue to look after the interests of our Veterans.

I greatly appreciate the honor which this Committee has bestowed on me. I express my great appreciation to you, to the other Members and to the staff for this recognition.

Mr. Chairman, with regard to the subject matter of this hearing, It is a pleasure to be here this morning to consider the budget requests for the Department of Veterans Affairs for fiscal year 2002. I join you and the members of the Committee in welcoming the Honorable Anthony J. Principi, Secretary of Veterans Affairs and representatives of the Veterans Service Organizations. I look forward to each of their statements.

Mr. Chairman, the President has outlined his budget blueprint. He referred to that document as "A Responsible Budget for America's Priorities." I am pleased that among the President's priorities is his commitment to revitalize National Defense. Included in that priority is his focus on high-quality health care and timely benefits. I look forward to working with you and the Administration in ensuring this priority is met, and the promise to our Veterans is fulfilled.

Mr. Chairman, I thank the witnesses for appearing here today and I look forward to reviewing the testimony.

Chairman SPECTER. Thank you very much, Chairman Emeritus Strom Thurmond. You honor us by being the President pro tempore of the U.S. Senate, and you honor us with your presence here and by being Chairman Emeritus.

The resolution recites only a few of the achievements during your extraordinary service of 47 years in the U.S. Senate, and before that Governor of South Carolina, and candidate for the Presidency of the United States in 1948, and your extraordinary devotion to duty including parachuting behind the lines in World War II when most men in excess of 40 at that time would have been at home enjoying comfortable leisure. But you have, indeed, set an example and have made a milestone.

Just one personal recollection. When Senator Howard Baker was the majority leader in 1981–82–83–84 he made it a practice to have all night Senate sessions to finish the work of the Senate. One evening, illustratively, when we were on the finance bill, at 11:45, standing next to the chairman of the Finance Committee, Senator Dole, he said, "There are 63 amendments pending, and amendments, like mushrooms, grow overnight. So we are just going to

work through the bill." At 6:30 a.m. when the sun came up, we finished the bill. We had about four or five roll call votes, many amendments had been withdrawn, some voice votes, and it was amazing how short the debate gets at about 3 a.m.——

[Laughter.]

Chairman SPECTER [continuing]. With 60 or 70 Senators on the floor, and 30 or 40 sleeping in the Cloakroom, and the shouts "a vote, a vote" would be heard, and the speeches were abbreviated.

But during those all night sessions, I made it a point to have a protracted bowl of soup with Senator Thurmond. And I learned about his tenure in the service with that young fellow Jack Kennedy, and Lyndon Johnson, his work with President Roosevelt and President Truman, and all of the legends. And, Strom, you are a living legend in your time.

In the absence of the ranking member, we will alternate across the aisle. I believe Senator Wellstone is next ranking Democrat.

Would you care to make a comment, Senator Wellstone?

Senator WELLSTONE. Mr. Chairman, I am sorry to be late. Have we heard from the Secretary yet?

Chairman SPECTER. We have not. But we will just take a moment or two.

Senator WELLSTONE. I will just take 1 minute to put the Secretary's comments at least in my context as a Senator. I was just meeting with the DAV, and have been at the joint hearing with PVA not too long ago with a lot of other organizations, and I know that the chairman has spoken out on this as well—and I think we have got a great Secretary of Veterans Affairs, I have said this to Tony, if I could call him Tony, when I met him, and I am so thrilled—but there is a concern about the budget.

And if I could make an announcement, Mr. Chairman, with your forbearance. On Wednesday at noon, I do want members of the committee to know that there is going to be an unveiling of the portrait of Secretary Jesse Brown at the VA building. It would mean everything in the world to Secretary Brown if we could be there. So I hope as many Senators as possible can be there. He is struggling with a difficult disease now. So it is really important for people to celebrate his work. So I want to mention that.

And then to say to you, I have no doubt about this Secretary's commitment. I have grave reservations about the budget in the context of the overall tax cuts budget. I do not think $1 billion does the job, for reasons that are real clear—Millennium Care, veterans' mental health services, uninsured veterans and how we deal with them. I think we are going to have to have a better budget. I think most all of us are committed to that.

And the only other thing I will say to you, Mr. Secretary, and to everybody, is I had the opportunity to be at a press conference with Heather French the other day introducing the bill that deals with homeless veterans, with Lane Evans on the House side, and I want to get that to all of my colleagues. About 30 percent of homeless adults in the country are veterans and this is a wonderful effort to put more of a focus on how we can really put the services to them. I want to get this, Mr. Chairman, to all of my colleagues, and I look forward to working with the Secretary. Thank you so much.

Chairman SPECTER. Thank you, Senator Wellstone.

Senator Campbell?

Senator CAMPBELL. Thank you, Mr. Chairman.

Mr. Secretary, welcome. I hope you will bear with us a moment or two while we say a few things about our colleague and friend, Strom Thurmond.

We live in a country, Mr. Chairman, where the word "hero" is bandied around pretty lightly. We hear about movie heroes and sports heroes and so on. My view of what a hero is, is a person that has made a commitment at great personal risk and sacrifice to make this a better Nation. Certainly, from that context, our colleague Strom Thurmond is a hero in my view.

About 5 years ago, Strom was down by the lower level about to get on the subway, and there was a man down there who was, I guess, partly deranged. And, maybe you remember this, Mr. Chairman, he hit Strom with his elbow, and Strom did not pay much attention to it. But I did, and the policeman down there did, too. The policeman and I both wrestled this guy down to the floor and got some handcuffs on him and turned him over to the Capitol Police where he was taken out of the building. But a few days later somebody said to me, "That sure was nice of you for coming to the aid of Strom Thurmond." I told them, "I was not coming to his aid, I was trying to protect that guy from Strom." [Laughter.]

Because knowing Strom's history as a real warrior, I am sure he could have done very well on his own.

There has been a lot written about Senator Thurmond. But I, like you, have had opportunities in the past on late nights when we would sit down in the Senate buffet at the table where Senators sometimes sit around and eat, to have coffee with him and talk. I can tell you, the things that are not written in those books about Strom are equally valuable. I would often ask him about his personal interaction with Harry Truman or John Kennedy or some of the people that you mentioned, some of the people that I will never have the good fortune of knowing. Those personal recollections of his about what he said and what Harry Truman said, things of that nature, they were absolute gems. They may never be recorded, but they were just a marvelous experience for me and something that I am going to be able to take away from here and consider myself fortunate and lucky, indeed, that I served with one of the really great men in American history.

I heard that he has been in office about one-fifth of the whole time we have had a United States form of government. That is a lot of years of service. I notice even now with all the years he has been here, and with all the wonderful awards he has gotten, and all the accolades from people who have cherished him and admire him, he is never too busy to talk to anybody. This is a body where egos tend to get fed a little bit, and some of us maybe get the idea we are a little more important than we really are. But if you watch Strom in the halls, it does not make any difference if he is speaking to a world leader or the young lady that operates the elevator. He treats them all the same, with dignity and graciousness, caring, and understanding. I think that is the real quality of a really great man.

He has never forgotten his roots. I lived in Japan a few years, and they have a saying in Japan, Mr. Chairman, and it is, "Be kind to the people you meet climbing Mount Fuji because they are the same ones you are going to meet on the way back down." Which is just a way of saying that you should never forget where you came from and the people that make this Nation great. Strom has not forgotten that. And, it has just been a delight for me to be able to work with him. Thank you, Mr. Chairman.

Chairman SPECTER. Would anybody else care to make a comment about Senator Thurmond?

[No response.]

Chairman SPECTER. Well, we have a busy agenda, Strom, so we shall proceed.

Yes, Senator Craig?

Senator CRAIG. Mr. Chairman, I am going to have to step out in a few moments to go Chair the Senate, so I would like to make a few comments, if I could.

Chairman SPECTER. We recognize Senator Craig.

Senator CRAIG. Mr. Chairman, first of all, let me thank you for the honor you have by this resolution bestowed on Senator Strom Thurmond. It is appropriate and befitting a person who we have all cherished knowing and who we have all benefited a great deal from knowing, and continue to do so.

The Chairman and I were in the elevator coming over here this morning and we were hustling to get here because we were reminded that if we were late, we would be late and Strom Thurmond would be early. I think that says so much about a person who at 98 years of age still serves and serves on schedule and on time. And that is exactly the case here. And as someone who has known Strom Thurmond by name and by reputation all of my political life, and then to have the privilege of serving with him in the U.S. Senate, that is, in fact, a great honor.

So, Mr. Chairman, thank you for honoring him today with this resolution.

Strom, congratulations on becoming the Chairman Emeritus of this committee.

I want to recognize our new Secretary. I look forward to working with him in the coming months and years as he works to build the confidence and the dignity of the Veterans Administration and provide the kinds of services to veterans that this committee expects our Government to do for our veterans. We will work with you in a cooperative manner. There will be times when we may criticize you but it will be in the constructive way of urging you on to make sure that the Veterans' Administration provides the services to America's veterans that are befitting and that in most instances were promised.

Over the last several years this committee has stepped forward and actually gone beyond what was the intent of the past administration because we did not feel we were meeting the targets and/or the responsibilities to our veterans. We will continue to do the same. I am not pleased with the level of budget that we see at this time. We are going to have to work to solve those problems to make sure that we maintain those levels of service. But I look forward

to you being here, and I apologize that I will have to step out of the committee.

Mr. Chairman, let me ask unanimous consent that my full statement be made a part of the record.

[The prepared statement of Senator Craig follows:]

PREPARED STATEMENT OF HON. LARRY E. CRAIG, U.S. SENATOR FROM IDAHO

Mr. Chairman, it is indeed a pleasure to be here with Veterans Administration (VA) Secretary Principi and representatives of five of our veterans service organizations. You all share a commitment to our Nations veterans and their families that honors their sacrifice and service. The American Legion, Veterans of Foreign Wars, Disabled American Veterans, Paralyzed Veterans of America, and AMVETS provide a wonderful service to our veterans which does not go unnoticed. I look forward to your testimony as we develop a budget that recognizes the immeasurable contributions veterans have made to this great country.

Last year we provided the VA with a blueprint for desperately needed services. We must review the President's preliminary budget proposal to ensure that it enforces the legislation that has been passed as well as looking forward to the future. I strongly support a VA which is committed to providing accessible high quality medical care and other veterans benefits and services in a timely and effective manner. The heroic defenders of our democratic way of life deserve nothing less.

I am looking forward to working with Mr. Principi to restore confidence of so many of our veterans who lost faith in the VA's ability to fairly and promptly respond to their many needs. Of primary concern is the time it takes to process benefit claims for compensation. Another concern is the long list of veterans waiting to receive various services, especially medical care. In recent years there were tremendous staff reductions that resulted in reduced services. The necessary steps must be taken to reverse this trend.

I also realize there are several additional issues that are a concern to America's heroes. The National Defense Authorization Act for Fiscal Year 2001 established a new Department of Defense (DoD) benefit for military retirees over age 64 who have Medicare coverage. We must work with DoD to ensure our veterans are properly served.

I expect a healthy and sometimes controversial debate related to the 2002 Department of Veterans Affairs budget submission. Because of the proposed increase from the FY01 appropriation, this budget should help enforce our commitment to our Nation's veterans. In order to do that we must recognize the tough fiscal decisions that must be made, and work hard to find the most cost effective ways to provide high quality services.

As a fiscal conservative, I believe it's critical to keep program funding consistent with a balanced Federal budget. In the long run, a balanced budget will serve all Americans, including our veterans. But, I also know that along with this commitment to a balanced budget, comes the responsibility to ensure our government honors its promises to our veterans.

In making policy decisions on veterans services, we must ensure the highest standards of care and service delivery. When we restructure the VA health care system to enhance our ability to provide healthcare to eligible veterans, we must not forget those living in underserved geographic areas and rural States. In southern Idaho, the initial steps were taken and clinics were provided in Pocatello and Twin Falls. But we must not forget the large population of veterans in the north who must drive over twelve hours to a clinic. A third clinic in Lewiston would provide desperately needed access to essential services.

I look forward to hearing from our representatives today. As the Congress continues to work on addressing the President's budget, the information from our witnesses will be crucial in providing ways to improve the delivery of services and benefits to our Nation's veterans.

In closing, Mr. Chairman, there is no way to over emphasize the honor and respect this Nation owes the military men and women who sacrificed so much. I look forward to working with all of our veterans service organizations who continue to contribute to the long-range vision for the Department of Veterans Affairs.

Senator THURMOND. Thank you for your kind words.

Senator WELLSTONE. Mr. Chairman, thank you for your resolution. I did not thank you for your resolution earlier.

And to Senator Thurmond, thank you.

Senator THURMOND. Thank you very much.

Chairman SPECTER. Since we have a very crowded agenda, I have two votes stacked at 11, and Secretary Principi would like to speak to the American Legion at 11, we will proceed at this time.

Mr. Secretary, we note that the President has submitted a total figure of $23.4 billion for fiscal year 2002, which is an increase of $1 billion from fiscal year 2001. We do not have any specification or details. We all know that we are looking at a very sacred obligation to America's veterans at a time of escalating cost and an aging veterans population.

We turn to you at this time.

STATEMENT OF HON. ANTHONY J. PRINCIPI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS ACCOMPANIED BY: THOMAS GARTHWAITE, MARK CATLETT, JOSEPH THOMPSON, AND ROGER RAPP

Mr. PRINCIPI. Thank you, Mr. Chairman. May I proceed with a short opening statement, or would you prefer, in the interest of time, to——

Chairman SPECTER. Your full statement will be made a part of the record, and a short opening statement would be fine.

Mr. PRINCIPI. Thank you, Mr. Chairman, and members of the committee. Congratulations, Senator Thurmond, on this very distinguished naming of you as Chairman Emeritus of this great committee. I applaud you, sir, for your service to our Nation.

It is good to be before the members of the committee. We are requesting more than $51 billion for veterans' benefits and services—$28.1 billion for entitlement programs, and $23.4 billion for discretionary programs such as medical care, burial services, and the administration of veterans' benefits. Our budget increases VA's discretionary funding by $1 billion or 4.5 percent over the fiscal year 2001 level. With an increase in medical care collections which will remain with the VA of approximately $200 million, this brings the total increase in discretionary spending to $1.2 billion or 5.3 percent.

Although all of the specifics of this increase are not quite worked out, I would like to give you a quick overview of how I intend to allocate those dollars.

The lion's share of the increase would go, of course, to medical care. Approximately $1 billion or 4.8 percent would be allocated to medical care. Of the $1.2 billion, 13 percent would be for the Veterans Benefits Administration. That is an increase of 13 percent or $134 million to allow us to get a handle on this enormous crisis we face in the claims backlog. An 11-percent increase, approximately $12 million, would be for the National Cemetery Administration to continue our expansion of National Cemeteries and to make a downpayment on the backlog of repair and maintenance to bring our cemeteries up to the status of national shrines. And, we would make our first investment in capital infrastructure a 20-percent increase over the 1991 levels of $78 million for major construction.

The budget ensures veterans will receive high-quality health care, that we will keep our commitment to maintain veterans' cemeteries as national shrines, and that we have the resources to tackle this ever-growing claims situation.

The President promised a top-to-bottom review of our benefits claims processing. He has designated this area as a key budget initiative and I have made it my most important priority. I know you share our commitment to restore the confidence of many veterans who have lost faith in our ability to provide timely and quality evaluations of their claims.

This requests fully implements the new legislation that strengthens VA's "duty to assist" role in helping veterans prepare their claims. We will be hiring 800 new people in our Veterans Benefits Administration; 100 of the 800 would be for our educational processing, 700 would go to rating claims in the disability compensation and pension area.

Additional resources will be coupled with a proactive approach to solving problems. I plan to establish a task force this month that will address claims processing and developing hands-on, practical solutions.

Our future approach to benefits delivery will incorporate a paperless technology. The Veterans Benefits Administration plans to consolidate the aging data centers into VA's core data center in Austin, TX. This is an important first step in realizing our vision for the future.

For veterans' health care, the budget request reaffirms our primary commitment to provide high-quality health care for service-connected disabilities or veterans with low incomes who really have no other option for health care. VA provides important specialty care and we need to ensure that we are funding spinal cord injuries, Post-Traumatic Stress Disorder, issues related to homelessness, mental health, drug and alcohol abuse treatment programs, to ensure we are in compliance with the Millennium Act and we are maintaining capacity at 1998 levels to provide for the specialized treatment and rehabilitative needs of disabled veterans, including veterans with spinal cord dysfunction, blindness, amputations, and mental illness, within distinct programs or facilities of the Department.

We also will be convening a task force to take a look at how our health care system interrelates with the Department of Defense, and to see how we can bring down the barriers between the two systems so that they can work closer together in partnership.

In our National Cemetery System, as I have indicated, we are increasing the Cemetery System's budget 11 percent. We have a lot to do to restore the situation in our National Cemeteries with regard to repair and maintenance.

In view of the time, Mr. Chairman, I will submit the rest of my statement for the record. Thank you very much.

[The prepared statement of Mr. Principi follows:]

PREPARED STATEMENT OF HON. ANTHONY J. PRINCIPI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman, and members of the Committee, good morning. Thank you for inviting me here today to discuss the President's FY 2002 budget proposal for the Department of Veterans Affairs.

As you know, the President released his budget blueprint on February 28, 2001. Additional information regarding specific funding levels for each of our programs will be provided early next month. I look forward to addressing the details of our request at that time. Until then, I am pleased to discuss the overall budget request for VA and my priorities for the next fiscal year.

We are requesting more than $51 billion for veterans' benefits and services: $28.1 billion for entitlement programs and $23.4 billion for discretionary programs, such as medical care, burial services, and the administration of veterans' benefits. Our budget increases VA's discretionary funding by $1 billion or 4.5 percent over the FY 2001 level. With an increase in medical care collections of approximately $200 million, this brings the total increase to $1.2 billion or 5.3 percent.

The budget ensures veterans will receive high-quality health care, that we will keep our commitment to maintain veterans' cemeteries as national shrines, and that we will have the resources to tackle the challenge of providing veterans more timely and accurate benefits claims determinations.

The President promised a top-to-bottom review of our benefits claims processing. He has designated this area as a key budget initiative and I have made it one of my top priorities. I know you share this Administration's commitment to restore the confidence of many veterans who have lost faith in VA's ability to fairly and promptly decide their benefits claims.

Mr. Chairman, as we all know, VA is not completing work on benefits claims in as timely a manner as our veterans deserve. I am proud to say this budget will rejuvenate VA's efforts to process compensation claims promptly and accurately.

This request fully implements new legislation that strengthens VA's "duty to assist" role in helping veterans prepare their claims. It also will enable us to carry out the new policy of adding diabetes to a list of presumptive conditions associated with exposure to herbicides. The 2002 budget provides additional staffing for these efforts. Additional resources will be coupled with a proactive approach to solving problems. I plan to establish a task force that will address claims processing and develop hands-on, practical solutions.

Our future approach to benefits delivery will incorporate a paperless technology. The Veterans Benefits Administration plans to consolidate its aging data centers into VA's core data center in Austin, Texas. This is an important step in realizing our vision for the future.

For veterans' health care, the budget request reaffirms our primary commitment to provide high-quality medical care to veterans with service-connected disabilities or low incomes. VA provides comprehensive specialty care that other health care providers do not offer, such as services related to spinal cord injury, Post Traumatic Stress Disorder, prosthetics and addiction programs. I am proud of our unique accomplishments and will insist on full funding to continue our leadership role in these areas.

We recognize the need to improve access to health care for eligible veterans. The budget supports the President's new health care task force, which will make recommendations for improvements. The task force will be comprised of representatives from VA and the Department of Defense (DoD), service organizations, and the health care industry.

The budget request also ensures that our National Cemeteries will be maintained as shrines, dedicated to preserving our Nation's history, nurturing patriotism, and honoring the service and sacrifice of our veterans. Funding will be used to renovate gravesites and to clean, raise and realign headstones and markers.

Mr. Chairman, our 2002 budget is not simply a petition for additional funding. It also reflects opportunities for cost savings and reform. VA will do its part to ensure the most efficient use of limited resources, while maintaining the highest standards of care and service delivery.

The National Defense Authorization Act for Fiscal Year 2001 established a new DoD benefit for military retirees over age 64 who have Medicare coverage. These retirees will be able to use their own private doctors for free care and receive a generous drug benefit. Currently, 240 thousand of these retirees are enrolled in VA's health care system. Our budget assumes that 27 percent of them will switch to the DoD benefit in 2002, which shifts $235 million in VA medical liabilities to DoD.

This recent legislative change underscores a critical need for better coordination between VA and DoD. The Administration will seek legislation to ensure DoD beneficiaries who are eligible for VA medical care enroll with only one of these agencies as their health care provider. We will work with DoD to avoid duplication of services and enhance the quality and continuity of care.

Restructuring efforts in our health care system will continue in 2002. VA has begun an infrastructure reform initiative that will enhance our ability to provide health care to eligible veterans living in underserved geographic areas. Savings from this effort will allow us to redirect funds from the maintenance of underused facilities to patient care. As we await the results of this assessment—referred to as "CARES"—we will continue to expand sharing agreements and contracting authorities with other health care providers.

The budget also includes legislation for several proposals that will yield mandatory savings totaling $2.5 billion over the next ten years. Most of these proposals will extend previously enacted mandatory savings authorities that would otherwise expire over the next several years.

Finally, we will continue to reform our information technology. New technology offers VA opportunities for innovation. It also offers a means to break down the bureaucratic barriers that impede service delivery to veterans, divide VA from other Federal government departments, and create inefficiencies within VA itself.

I have gone on record as stating that I will not initiate any new technology-related activities until an integrated strategy for addressing our information systems and telecommunications is developed. We will continue to improve coordination among our three administrations to implement a technology plan that serves veterans first. Reforms will include developing a common architecture, establishing common data definitions, and coordinating systems across VA.

Mr. Chairman, that concludes a general overview of VA's 2002 budget request. I thank you and the members of this Committee for your dedication to our Nation's veterans. I look forward to working with you. My staff and I would be pleased to answer any questions.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. ARLEN SPECTER TO ANTHONY J. PRINCIPI

HEALTH CARE ISSUES

Question 1. The Veterans Health Care Eligibility Reform Act of 1996 requires that VA maintain capacity to treat special needs populations such as veterans with spinal cord injuries, blindness, mental illness, and homeless veterans. Will the current funding proposal be adequate to continue timely and quality health care for these special populations?

Answer. Yes, the current funding proposal will be adequate to continue timely and quality health care for these special populations.

Question 2a. Over the past few years, VA has been transformed from a hospital-based provider to one that relies on ambulatory settings to meet veterans' needs. This surely assists VA in meeting the primary care needs of veterans—but I am concerned that specialty care is being compromised. Can VA provide adequate mental health services in an outpatient setting?

Answer. VA has been providing the bulk of its mental health services on an outpatient basis for many years. In the 1960's VA pioneered the development of partial hospitalization programs such as Day Hospitals and Day Treatment Centers, as supplements to traditional outpatient clinics, in an effort to keep more VA patients in the community. It is true that in recent years more of our mental health care has shifted to outpatient settings. In FY 1994, VA served 125,045 veterans in inpatient mental health units, 23 percent of the 541,261 mental health patients seen that year. In FY 2000, only 75,745 veterans had inpatient mental health care, 11.2 percent of the 678,932 seen that year. Although VA is increasing its outpatient mental health services for veterans, nonetheless, we are still mindful of those veterans whose severity of illness requires inpatient care. It should also be noted that nearly 99 percent of veterans who received inpatient mental health care in FY 2000 also received outpatient mental health services.

VA has been working to enhance our outpatient capabilities for our most severely mentally ill veterans through the development of Mental Health Intensive Case Management (MHICM) programs, which are designed help these patients adapt to community life. Forty of these programs are now operating, and we are currently engaged in a system-wide increase in MHICM activity. We also are working to increase the mental health capability of our Community Based Outpatient Clinics (CBOCs), which are designed to bring health care closer to where veterans live. Currently, about 50 percent of CBOCs have mental health capability, and we are striving to increase that percentage. Furthermore, we are developing ways to enhance the involvement of mental health staff in medical and geriatric primary care settings to provide care to veterans who need mental health services in the familiar surroundings of the primary care clinic.

Question 2b. Can it provide adequate blind rehabilitation services in an outpatient setting?

Answer. VA cannot provide comprehensive blind rehabilitation in an outpatient setting. Limited portions of blind rehabilitation programs can be met in an outpatient setting, but early preliminary data from outcome measures indicate that VA residential programs are far superior to all other models of blind rehabilitation, in-

cluding state, private, and VA outpatient models. Nonetheless, as the number of older veterans increases, VA's Blind Rehabilitation Outpatient Specialists (BROS) may play a more significant role in blind rehabilitation. Currently, VA has only 19 BROS, and they have proven to be most effective in supplementing the services provided by the residential programs.

Question 3. There are close to 500,000 veterans service-connected for mental illness. Over the past five years, VA spending on mental health care has declined by 8 percent. To what do you attribute this decline in spending? Has VA become a markedly more efficient provider of mental health services? Or is VA neglecting the need of veterans with mental illnesses?

Answer. In 1996, there were 456,527 veterans service-connected (SC) for a mental health disorder. Of these, 167,845 (37 percent) were receiving care in VA facilities. By FY 2000, there were 452,890 veterans SC for a mental health disorder. Of these, 191,243 (42 percent) were treated in VA facilities. This reflects a 14 percent increase in the number of veterans treated in VA facilities for an SC mental health disorder.

For patients with a serious mental illness, VA has shifted from a system of care that heavily relied on hospital care to a comprehensive continuum of care, ranging from outpatient care in the community through partial hospitalization settings, residential care, and intermediate hospital settings, to high intensity hospital care. Our clinicians have found that many patients with serious mental disorders could be treated for much shorter lengths of stay, and in intermediate, residential, or supportive community settings. In these settings, patients have a larger participation and role in their treatment and more freedoms than in often over-protective hospital settings.

Over the last five years, we have seen an 8 percent increase in the number of veterans with a mental illness who were either hospitalized or received significant outpatient mental health treatment (6 or more visits per year). This has been accompanied by an 8 percent decrease in specialized mental health costs. The lower mental health costs most likely reflect two factors: (1) a 33 percent decrease in the number of psychiatric inpatients, from 113,719 in FY 1996 to 75,745 in FY 2000; and (2) a 39 percent decrease in overall average length of stay, from 27.3 days in FY 1996 to 16.6 days in FY2000.

Thus, the decreased costs actually reflect a more modern and effective approach and philosophy for treating veterans with mental disorders, rather than a neglect of their needs.

Question 4. While the total veteran population is declining, the female veteran population is rising; now there are over 1.2 million women veterans. Even so, approximately one-third of VA hospitals do not have women's clinics. Does this budget contain funds to increase services and provide appropriate facilities for women veterans? If not, should it?

Answer. With the exception of the elderly veteran population, female veterans are the fastest growing segment of the veteran population. In FY 2000, women veterans comprised roughly 1.4 million of the Nation's 26 million veterans, or approximately 5.5 percent. In facilities without formal "women's clinics", gender-specific health services are provided by women's health personnel in women's health specialty clinics, while primary and preventive medicine services are performed by gender-neutral primary care teams. VA has acknowledged the growing population of women veterans by establishing Women Veterans Health as a special program with designated headquarters and field staff. The needs of women veterans are included in the VERA model in the FY 2002 budget. Infrastructure challenges related to privacy exist and are being addressed.

Question 5a. VA leads the nation—as it should—in the treatment of Post Traumatic Stress Disorder (PTSD). I want VA to continue to so lead the nation. Can VA effectively treat PTSD in an outpatient care setting?

Answer. Yes. Consistent with all health care systems, the preponderance of care for PTSD can be and is being provided effectively on an outpatient basis.

Question 5b. Is this an area where VA must continue to provide care on an inpatient basis?

Answer. Yes. Although the preponderance of care can be provided effectively on an outpatient basis, VA is committed to maintain appropriate inpatient capacity to provide clinically-indicated and necessary treatment.

Question 5c. Can VA adequately provide needed care for PTSD under this budget proposal?

Answer. Yes. Public Law 106–117 provided $15 million for new specialized PTSD and Substance Use Disorder care in VHA. These funds were awarded through a competitive Request for Proposal (RFP) process. Approximately $5.5 million of this amount was distributed to fund new PTSD treatment programs. VISNs received this funding with the requirement to maintain these services through FY 2002.

Question 6. During the appropriations process in the Senate last year, Chairman Bond of the Senate VA-HUD Appropriations Subcommittee placed a moratorium on new major construction projects until VA showed positive movement implementing its Capital Asset Realignment for Enhanced Services ("CARES") process. Where does VA now stand on "CARES"? Will VA need to proceed with any major construction this year-prior to completion of the CARES process?

Answer. The CARES contractor, Booz-Allen & Hamilton, has projected that they will complete their CARES Report on VISN 12 by the end of May. I am to receive recommendations in June. During the May–July period, we will be consulting with stakeholders, evaluating the overall CARES process, and applying lessons learned from the Phase I pilot to the Statement of Work for the Phase II markets. Since the remaining 21 VISNs will follow the process and methodology developed in Phase I, VA is carefully working through the process the first time. Adjustments to the database and communications portions of the task have been required, and it is anticipated that more adjustments to the CARES process will be made following the lessons learned overview of Phase I. Phase II is targeted to be started in summer 2001, and Phase III in summer 2002. Phase II and III will be completed a little more than one year after initiation.

VA will need to proceed with select major construction projects prior to the completion of the CARES process, especially those addressing safety-related issues for our patients and employees. For FY 2002, we are proposing an emergency electrical project at Miami, FL, in the major construction account. Over the next several years, while the CARES studies are underway, increased funding for such projects will be required. In particular, projects to correct seismic deficiencies should proceed at those facilities we expect to be identified as health care sites in the CARES studies.

Other needed improvements and renovations at over 4000 aging buildings at VA medical centers, national cemeteries and regional offices will be addressed through the minor construction program. Our FY 2002 request includes $178.9 million for minor construction projects, $25 million of which is dedicated to CARES projects.

Question 7. The Veterans Millennium Health Care and Benefits Act of 1999 requires VA to provide nursing home care to all veterans who are 70 percent or more service-disabled if they seek—and need—such care. At the time of enactment of this mandate, VA advised the Committee that it might have problems implementing this charge. Has VA had such problems? Are any "70-percenters" who need nursing home care being denied such care by VA? Will they be under this budget request?

Answer. VA has not had difficulty in implementing the mandate to provide nursing home (NH) services to veterans who need such care for a service-connected disability or who have a disability rated 70 percent or greater and need NH care. VA estimates that approximately half of the service-connected veterans rated 70 percent or higher who are eligible for NH care under this Act receive their care through one of the three VA-sponsored NH Programs. The budget request for FY 2002 contains sufficient funds to meet the NH care needs of all the service-connected veterans covered by this statute who might seek NH services from VA.

Question 8a. Last year, VA announced its "30–30–20" initiative—a program designed to reduce patients' waiting times by assuring that a veteran would receive an initial visit at a VA facility within 30 days of requesting enrollment; see a specialist within 30 days of referral; and been seen by a provider within 20 minutes of arriving at a VA facility. Despite this initiative, veterans are experiencing waiting times that are unacceptable—for example, in Lebanon, Pennsylvania, veterans seeking to enroll for VA care are forced to wait up to 7 months or more before they can see a primary care provider. Are the goals of the "30–30–20" initiative realistic?

Answer. VHA's goal is that clinic wait times will be significantly reduced over several years. The specific targets established for 2003 are:

- 90 percent of non-urgent primary care patients scheduled within 30 days.
- 90 percent of non-urgent specialty care referrals (eye care, audiology, orthopedics, cardiology, urology) scheduled within 30 days.
- 90 percent of patients seen within 20 minutes of their scheduled appointment time.

I believe that the 30–30–20 goals are very aggressive and benchmarks are not available for access and waiting times goals in other health care systems. However, VA believes that these goals are important and are consistent with veteran expectations, and I am told that they are obtainable over time. Performance data will soon be available showing the progress we are making towards meeting these specific targets. We will begin monitoring our progress, nationally and by medical center, in June. I will be receiving regular reports, which will be available to you, as well as all of the members of our authorizing and appropriations committees.

Performance Data on Access—July 2001

VHA's Fiscal Year (FY) 2002 budget submission included goals for clinic wait times:

• 90% of enrolled veterans will be able to obtain a non-urgent patient appointment with their primary care provider or other appropriate provider within 30 days.

• 90% of patients will be able to obtain a non-urgent appointment with a specialist within 30 days of the date of referral.

In May of 2001, 87% of all primary care appointments were scheduled within 30 days of the desired date and 82% of specialty clinic appointments were scheduled within 30 days of the desired date.

Attachment A includes longitudinal data on average clinic waiting times (for non-urgent, next available appointments) and best demonstrates the dramatic improvements made by VHA over the last year.

ATTACHMENT A

Average Waiting Time To Next Available Appointment—2000

VHA	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Prim	65.1	64.4	63.8	62.8	61.8	60.4	60.5	58.2	58.5
Eye	101.0	94.2	93.8	88.0	90.1	83.7	86.7	89.8	89.1
Audio	49.9	50.1	52.1	50.2	47.1	40.3	43.8	44.4	47.1
Cardio	51.7	53.0	48.0	47.0	45.4	44.5	44.3	43.6	44.7
Ortho	44.6	46.7	44.8	42.0	44.6	40.1	43.3	43.4	43.1
Uro	80.7	78.7	74.1	72.5	69.3	69.1	67.8	71.6	74.1

Average Waiting Time To Next Available Appointment—2001

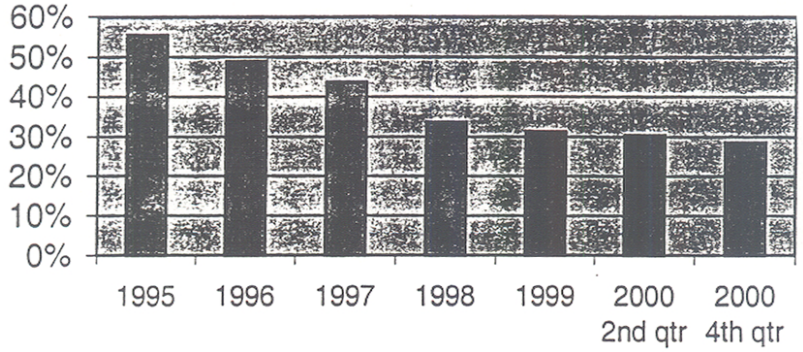
VHA	Jan	Feb	Mar	Apr	May	May 01–Apr 00	
						Dif	% Dif
Prim	56.1	54.6	44.4	42.6	42.6	−22.5	−34.6
Eye	80.6	83.7	72.9	72.3	69.6	−31.4	−31.1
Audio	43.9	45.3	39.7	38.2	40.4	−9.5	−19.0
Cardio	41.6	40.6	40.4	37.5	41.9	−9.8	−19.0
Ortho	45.3	40.6	39.7	39.2	38.3	−6.3	−14.1
Uro	77.1	67.8	52.7	53.0	52.8	−27.9	−34.6

VHA's FY 2002 goal for in-clinic waiting times is:

• 90% of patients should be seen within 20 minutes of the scheduled appointment time.

The time that patients wait to see their provider has greatly improved VHA-wide. The chart in Attachment B shows the percentage of patients who report waiting longer than 20 minutes beyond their appointment time to see their provider. The decreasing percentage demonstrates the clear performance improvement. (Source: Veterans Customer Satisfaction Surveys 1995–2000.)

ATTACHMENT B.—PERCENT OF OUTPATIENT RESPONDENTS WHO REPORT WAITING >20 MINUTES TO SEE THEIR PROVIDER



Question 8b. If so, what financial resources will be devoted to implementation of the "30–30–20" plan for fiscal year 2002?

Answer. An increase of $164 million is requested in the FY 2002 budget for this purpose. According to the Networks financial plans, this increase would be in addition to an estimated $294 million recurring in the base and would increase the program funding level to $458 million in FY 2002.

Question 8c. When can veterans expect to see results?

Answer. I too continue to hear complaints from veterans and others about excessive clinic waiting times. However, I am told that improvements are being made. Between April 2000 and December 2000, primary care clinic times decreased by ten percent and specialty clinic waiting times decreased by approximately nine percent. It is important to note that these decreases were accomplished at a time when the total number of VHA outpatient visits was significantly increasing due to greater demand for outpatient care.

Of equal or possibly greater importance are patients' perceptions of waiting times. VHA's most recent customer satisfaction survey (FY 2000) shows that 80 percent of patients report appointments scheduled at times that are convenient to them. Similarly, 85 percent of patients report waiting less than 30 minutes to be seen by their providers.

Specifically, at Lebanon VAMC, information from patient interviews with veterans during the past several months indicates that the majority of veterans are enrolling because Medicare HMO's are pulling out of central Pennsylvania. This dramatic recent increase in enrollees, coupled with an 11 percent general increase in enrollees using the facility in FY 2000, has resulted in the establishment of the current waiting list.

To deal with this issue, the medical center has initiated recruitment of 18 additional Primary Care staff positions. These positions will be located where the need is greatest. An additional primary care team (M.D., Nurse Practitioner, RN, LPN, and two clerks) is being added to the Lebanon VA Medical Centers. An additional Physician Assistant, LPN, and clerk will be added at both the Lancaster and Berks CBOCs. Recruitment of staff for the newly approved York County CBOC (M.D., Physician Assistant, RN, LPN, and two clerks) should allow CBOC opening in May 2001. The Lebanon VA Medical Center has briefed area veterans' organizations, County Directors of Veterans Affairs, and congressional offices on a bimonthly basis on the status of this waiting list. The medical center also has provided stakeholders an opportunity to provide input and to gain an understanding of why the waiting list has occurred and what specific strategies are being implemented to eliminate the list. These briefings have fostered a clear understanding of the situation and have enlisted the stakeholders' unanimous support.

Recognizing these indications of improvement, complaints about waiting times are consistent at all of my visits to our medical facilities. As we monitor these standards, we will ensure accurate reporting with appropriate oversight by the Inspector General and other auditing offices.

Question 9a. It is reported that the Nation—and VA—will soon experience a significant nursing shortage. How can VA assure adequate nurse staffing?

Answer. VA closely monitors nursing staff demographics, gauging the sufficiency and availability of nursing staff at a national level. In addition, every effort is made

to support VAMCs as competitive employers in local communities. VA has begun comprehensive policy development related to nurse staffing, including competitive pay, recruitment, and retention bonuses, work environment, occupational health and safety, as well as education initiatives and a loan repayment program.

Question 9b. Do you believe that VA has a role to play in helping to recruit more young people into the field of nursing?

Answer. VA facilities do have a role in recruiting more young people into the field of nursing. One such successful program is the VA Cadet program implemented at VA Medical Center Salem, VA. This program brings high school students into the VAMC for educational and volunteer experiences in nursing. VA would welcome the opportunity to participate in a broader, national effort to increase the number of individuals choosing nursing and other health care profession careers.

Question 9c. Does VA have any plans or programs in place to help sustain the proper level of nursing staff?

Answer. VA has initiated the Nursing Workforce Planning Group with the directive to identify the impact of the predicted nursing shortage on VA and to recommend strategies and actions to maintain a qualified nursing workforce in VA. This multidisciplinary group is engaged in a number of comprehensive activities that will lead to immediate, short-range, and long-range activities. Currently, VA operates the Veterans Affairs Learning Opportunities Residency Program (VALOR), an internship program aimed at recruiting high-performing baccalaureate students for specialized clinical experiences and eventual hire by VA facilities. VA's National Nursing Educational Initiative (NNEI) has made $50 million available to registered nurses who are obtaining baccalaureate or higher degrees and the Employee Incentive Scholarship Program (EISP) provides funds to VA employees enrolled in programs leading to a degree in nursing.

Question 10. You have stated that you are reviewing the costs associated with providing care to so-called "Priority 7" patients-those who are not service-connected, poor, or entitled to priority enrollment on other grounds. As I understand it, "Priority 7" now comprise 20 percent of VA's patient population—up from only 4 percent just five years ago. VA asked for "eligibility reform"—the change in the law that has made the full continuum of VA care available to even non-"priority" patients. In so doing, VA led Congress to believe that it would be able to handle such an influx of patients—due, in part, to the fact that VA would be able to collect, and retain, insurance reimbursements and co-payments from such patients. Is that no longer the case?

Answer. I will make the enrollment decision for FY 2002 later this year. If availability of sufficient resources becomes an issue, different policy decisions and options will need to be considered. Enrollment of Priority 7s is anticipated for FY 2002 with the recognition that fewer will be treated by the VA than in FY 2001 due to TRICARE for Life and higher copayments for Priority 7 veterans we expect to implement this fall. However, let me assure you that the FY 2002 budget request reaffirms our primary commitment to provide high-quality medical care to veterans with service-connected disabilities or with low income.

Question 11. I led the fight some years ago for legislation allowing VA to retain insurance company collections so that VA would have an incentive to pursue such reimbursements. I then followed up with legislation allowing the collecting VA Medical Center to retain any and all funds collected by its staff. Even so, should I conclude that there are not sufficient incentives for VA to pursue such funds? What else can Congress do to energize collections? What will you do to energize collections?

Answer. VA is committed to improving revenue and collections and increases are already occurring. For the first half of FY 2001, monthly collections have been 50 percent ahead of last year. For FY 2002, increased co-payments for pharmacy, long-term care, and outpatient care will provide additional revenue. Specific proposals for improvements to increase the collections from insurance companies will be identified soon. I am directing VHA to provide a detailed plan in 90 days to improve dramatically the documentation and coding by physicians, identification of insurance, and identification of changes in the billing and collections process. These will be implemented in FY 2002 with accountability for these improvements to the local facility and individuals as necessary.

Question 12. The VA State Home Grant Program—a partnership that allows the Federal Government and the States to work together to provide high quality long-term care to veterans—has been a major success in Pennsylvania and throughout the U.S. Will this budget proposal allow this program to grow? What are your plans for the State Home Grant Program?

Answer. Yes. The funding request in 2002, when combined with unobligated funding from previous years' appropriations, represent a continued commitment to sup-

port VA-sponsored nursing home care through less expensive State and community programs.

The Veterans Millennium Health Care and Benefits Act (Public Law 106–117) required VA to revise the State Home Construction Grant regulations. Interim regulations will be issued in June and in place for the FY 2002 grant funding cycle. The revised methodology provides a higher priority for renovation projects with the highest priority for projects that remedy life safety problems. The new methodology also requires that existing VA and community nursing home beds be considered when ranking bed-producing projects for funding.

Question 13. The Veterans Millennium Health Care and Benefits Act of 1999 requires VA to pay for veterans' emergency room visits in certain circumstances—starting in May 2000. Even so, I am advised VA has not implemented this mandate and that it is collecting information from veterans about their emergency room visits. Why is VA collecting information rather than paying bills? When will VA implement this statutory mandate?

Answer. Section 111 of the Veterans Millennium Health Care and Benefits Act of 1999 required VA to prescribe regulations to establish the maximum amount payable and to delineate the circumstances under which payments may be made. The implementing regulations for the emergency care provision were completed and forwarded to OMB for review in November 2000. On February 3, VA withdrew all regulations to allow my staff to review any regulations developed by the previous administration. The revised regulations were returned to OMB on April 11, 2001. Among revisions made to the proposed rules prior to their resubmission to OMB was the addition of a requirement that a claimant must certify, in writing, that a claim meets all of the conditions for payment and that he or she is aware of the criminal penalties for obtaining payments with the intent of defrauding the United States.

Because regulations were not published prior to the May 2000 effective date, VA health care facilities were advised in July 2000 to begin tracking and documenting claims that may meet the criteria of the emergency care provisions. It is anticipated that these implementing regulations will become effective before the end of this year. Once final regulations are published, VA will retroactively reimburse any claimant back to the effective date of the legislation if the veteran meets the eligibility requirements set forth in the regulation.

Question 14a. The operation of VA's Veterans Equitable Resource Allocation (VERA) system has raised many concerns among members of this Committee. As I understand it, this funding allocation formula does not take into account the number of "Category 7" veterans that a given Veterans Integrated Service Network (VISN) is treating. As a result, areas like Pennsylvania that have many "Category 7" veterans who are coming to VA seeking care are squeezed by this formula. Do you anticipate any changes in the methodology used in calculating resource allocation among the various VISNs to rectify this situation?

Answer. VERA provides funding for Priority 7 veterans who are classified in the Complex Care category. VHA is currently examining the issue of providing workload and funding credit for Basic Care Priority 7 veterans in VERA. This issue will be carefully considered and will be influenced by the improvement in cost recovery from insurance companies and Priority 7 veterans to be outlined in the detailed plan mentioned in my response to question 11.

Question 14b. Do you think it is right for VA to open outpatient clinics and stimulate demand for VA care and then to deny—of at least delay unreasonably—such care when veterans seek to enroll?

Answer. The relationship of the large increase in Priority 7 veterans and the complaints on waiting times that I am hearing will be evaluated. There will be no new CBOCs approved for opening until I have approved a policy on placement of CBOCs. VHA is committed to ensuring that patients do not experience delays in receiving care and, to that end, has undertaken significant initiatives to reduce patient waiting times. We will continue to monitor and evaluate our CBOCs and patient waiting times.

Question 15. It has been proposed that VA modify VERA to account for the fact that veterans who are classified as "priority" patients on the basis of a "means test" might properly have their "means" judged by different measures in different parts of the country because of variances in the costs of living from place to place. Does this proposal make sense to you? Is VA considering it?

Answer. Linking a veterans "means" to geographic cost-of-living variances might serve veterans better than the current one-tier test. However, reviews performed in 1989 and 2000 indicate that it would pose a number of challenges for the Department. For example, veterans living in close proximity of one another, and receiving health care at the same facility, could potentially have their "means" judged differently, even though they may have identical or similar income.

Another challenge would be how to properly handle veterans who relocate at certain times of the year to another State. VA would need to decide which county or region to use in calculating their "means." Lastly, since VA currently uses a one-tier test to determine a veteran's means, this proposal would have a major impact on VA's Information System. I believe we must study this proposal carefully and evaluate the impact it would have on VERA against the potential benefits veterans may derive from this or a similar proposal. The Under Secretary for Health has convened a group to examine the impact of this proposal on VERA as well as on VA's Information System. Upon completion of their review, I will submit a full report of their findings to the Committee on Veterans' Affairs.

Question 16a. Advances in pharmaceutical science have assisted VA in its transition from hospital-based to an outpatient care-based health care provider. Along with these advances, VA's cost for medications has increased dramatically—making pharmacy costs a large percentage of total medical care expenditures. Please describe the strategies VA has undertaken to keep pharmacy costs under control.

Answer. VA supported the passage of Public Law 102–585, which gives VA, DoD, the Coast Guard, Public Health Service, and the Indian Health Service pricing for many high cost medications base-lined at the non-federal average manufacturer's price, minus 24 percent. VHA also supported a pilot allowing a commercial vendor to supply drugs to VA medical facilities. This eventually led to closure of VA's historic depot system. By closing the depots, VA moved from expending $18 million annually in 1992 dollars for drug warehousing and distribution to receiving approximately $50 million annually today for procuring most of its pharmaceuticals through a commercial prime vendor—a savings rate of approximately $68 million per year.

In 1992, the development of VA's national drug utilization database began, which served as the foundation for the establishment, in 1995, of a systems approach to pharmacy benefits management. National contracts and FSS blanket purchase agreements directly linked to the development and promulgation of pharmacological treatment guidelines helped VA avoid nearly $778 million in unnecessary drug costs from 1995 through 2000. Pharmacy benefits management has contributed to VA's ability to treat 500,000 new patients between 1995 and 2000, has increased equitable access to needed pharmaceuticals through the implementation of a national formulary process in 1997, and has driven unit costs downward. VA's pharmacy benefit management process is driven from the grass roots and receives substantial support from practicing physicians across the system.

Question 16b. Are VA formulary policies adequate to keep costs down while still assuring that VA patients get the best care possible?

Answer. Yes. VA's formulary policy is designed to manage costs and provide quality care, while assuring access to medically necessary drugs. VA's guiding principle for formulary management and the overall management of the pharmacy benefit is to provide enrolled veterans with "quality medical care at an affordable price." Operating within this maxim, the decisions VA makes regarding the pharmaceuticals available to treat veterans are driven by groups comprising 12 practicing physicians and representatives from each of the 22 Veterans Integrated Service Networks. These two groups determine the appropriate clinical strategy at a given point in time, which then drives the contracting process. VA's ability to determine an evidenced-based clinical strategy that best fits the needs of veteran patients, solicit bids in selective high-volume/high cost therapeutic classes, and then utilize the contracted products has produced significant cost avoidance, while increasing access to needed pharmaceuticals. The Institute of Medicine (IOM) in its June 2000 report on VA's National Formulary Process documented this outcome. The study by IOM and the preparation of the report was mandated by language contained in the House Report (105–610), which accompanied Public Law 105–276, the Fiscal Year 1999 Department of Veterans Affairs and Housing and Urban Development Appropriations Act. A copy of the report is attached.*

VA, through its Pharmacy Benefits Management Strategic Healthcare Group, is committed to regular physician surveys on pharmacy benefits. These surveys assess the perceived impact of our formulary policies on access to appropriate pharmaceuticals and the quality of care. Two surveys have been completed, and the results of these surveys are used to inform and assist policy. The results of the first survey were published in the March 2001 edition of the American Journal of Managed Care.

Inasmuch as VA's national formulary system is dynamic, adjustments are planned based upon recommendations from the above-referenced IOM report and two General Accounting Office reports on the formulary process (December 1999 and Janu-

*Note: The information referred to has been retained in the committee files.

ary 2001). However, in spite of the success of VA's formulary system, outlays for pharmaceuticals are expected to increase. The increases are being driven by utilization and new technology.

Question 17a. Last year's Defense Authorization Act created a new benefit dubbed "TRICARE for Life" by allowing military retirees over age 64 to remain under DoD-funded care despite Medicare eligibility. The Administration's budget proposal apparently assumes savings of $235 million in VA health care costs as a result of this legislation, based on the assumption that military retirees who had lost TRICARE eligibility at age 65 and who had come to VA for care will now stay within DoD's TRICARE system. What is the basis for the assumption that it will save $235 million? How did the Administration arrive at this number?

Answer. The Administration estimated that approximately 27 percent of military retirees who are age 65 or older and currently enrolled in the VA health care system would voluntarily choose to shift their medical care to the TRICARE system. The following figures were used in the calculations:

- 64,540 enrollees at an average cost of $3,705 per enrollee equal $239,120,700.
- This amount is then reduced by the nearly $4 million in collections that would otherwise have been anticipated for those enrollees.
- The net savings is, thus, approximately $235 million.

Question 17b. I am told that VA may request legislation to require military retirees over age 64 to choose either VA- or DoD-provided care. Is this so? Do you believe it is fair to require men and women who have served 20 or more years and who, therefore, are eligible for care under both systems to waive eligibility to either?

Answer. At this time the Administration has proposed legislative language to allow DoD beneficiaries, who are also eligible for VA medical care, to enroll with only one of those agencies for their health care. Coordination within the Administration among OMB, DoD, and VA has begun. More details in the proposal should be available soon.

White Paper—VA Requesting Legislation to Require Military Retirees Over Age 64 to Choose VA or DoD Provided Care

Medical Sharing Office (176), June 2001

The President's Budget Message, "A Blueprint for New Beginnings" (February 28, 2001), proposed that DoD beneficiaries, who are also eligible for VA medical care, enroll with only one of these Federal government health systems as their health care program. This concept has been under review at VA, DoD and the Office of Management and Budget. DoD is considering proposing legislation for annual enrollment for care in either health system to avoid duplication of benefits and enhance continuity of care. VA is unable to provide an estimate on when DoUs review will be completed.

In addition, improving coordination of VA and DoD health care will be addressed by the "President's Task Force to Improve Health Care Delivery for Our Nation's Veterans," created by Executive Order on May 28, 2001. The task force will also identify ways to improve benefits and services for veterans who are also military retirees. The Executive Order states that the task force will issue an interim report in nine months and a final report within two years.

Question 18. As you may know, I strongly support Federal investments in medical and biological research, and I am pleased that President Bush agrees that Federal funding of medical research must increase dramatically. VA's research budget for FY 2001 is $350 million. Do you anticipate requesting that VA research funding be increased in fiscal year 2002? If so, by how much?

Answer. An increase of $10 million is requested for the research appropriation to reach a level of $360.237 million in FY 2002.

NON HEALTH CARE BENEFITS ISSUES

Question 19. The President has promised a "top to bottom" review of the disability claims process, and you, in your confirmation testimony, announced that a task force would be created to put the President's promise into effect. Has this task force yet been appointed? When will it be? When will it conclude its deliberations?

Answer. On April 16, 2001, we held a preliminary meeting of the special Claims Processing Task Force that will address claims processing and develop hands-on, practical solutions to the challenges we face. The 10-person task force, headed by retired Vice Admiral Daniel L. Cooper, will examine a wide range of issues affecting the processing of claims, from medical examinations and information technology, to efforts to shrink the backlog and increase the accuracy of decisions. The panel's final report is due to me in approximately 120 days.

Question 20a. In your testimony, you proposed a specific increase in VBA spending to address the backlog in VA's disability claims process.

Inasmuch as your task force has not yet, I believe, made recommendations for reforms, how would you propose that this additional money be spent?

Answer. Of the total VBA request, $775.5 million in total obligations will fund the Compensation and Pension Program reflecting an increase of $94.6 million over the FY 2001 current estimate. Included in this total is $44.5 million dedicated to initiative funding. Direct FTE levels for C&P increases by 863 for a total of 7,351 FTE in FY 2002. The majority of the increased FTE counters the effects of recently enacted Veterans Claims Assistance Act and Diabetes regulations. Our efforts are focused on effectively training these new hires to ensure we continue in our mission to process claims more efficiently and with greater accuracy. Continued support of initiatives like the Training and Performance Support Systems, Benefits Payment Replacement System (VETSNET Migration), Virtual VA, and the One VA Telephone Access, moves VBA towards achieving its vision of processing claims accurately and in a timely manner. We are committed to utilizing our most recent information technology advances while pursuing an aggressive strategy to address the current situation. Funding will allow continued and deliberate actions to maintain current achievements, invest in productive endeavors, and research enhanced business practices. In addition to these initiatives, many of which fall into the category of long-term process improvement efforts, I look to the Task Force to recommend practical changes that will result in immediate cycle time reductions.

Question 20b. Do you believe that your task force will necessarily issue recommendations consistent with the proposal under which you intend to spend that additional funding if it is granted to you?

Answer. Yes, I fully expect the task force recommendations will support our budget request. However, if our current outline for spending funds is not supported by the task force findings, we will align resources to provide optimal service to veterans.

Question 20c. If you are now recommending very substantial increases in VBA funding, what function do you intend your task force to serve?

Answer. The kind of systemic challenges that exist and inhibit timely and accurate claims processing need a top-management focus and a plan of action that can be embraced at the Department level, and supported through the ranks as an aggressive plan for long-term action. I believe the task force can focus on such a plan and present me with the blueprint for changes, which can improve our service in this area. The short-term initiatives shown in the budget are necessary and will have an impact in dealing with our current crisis, but we need to go beyond that and fix this problem once and for all.

Question 21a. During your confirmation hearing, you stated that VA had spent $30 million, since 1995, on information technology resources—without noticeable improvements. Do you now believe that you were wrong in suggesting that information technology spending had been ineffective?

Answer. No. In my opinion, information technology spending has not been as effective as it should be. I remain concerned that our IT achievements have not lived up to expectations. I have stated in previous testimony that we will not throw good money after bad. The approach VBA is now taking as they proceed with the VETSNET program illustrates the critical review to which I believe all major IT expenditures must be subjected.

I have directed that before we proceed to a fully operational status on VETSNET, we will conduct an independent audit of the overall system. This audit will provide us with the assurance that this system will meet all of the security, functional, and performance requirements we have set for it. If it passes these tests, we will go forward with its implementation on the current schedule. If not, we will develop a plan to extend the life of the current systems and immediately begin the development of a replacement system.

If this current version of VETSNET does not meet our needs for the next several years, we will terminate its development. Conversely, if it does meet our needs, we will not hold past failures against it, and we will go into production with the system. I have been assured that VETSNET is being developed in an open architecture to facilitate eventual integration into a future system and that it should fit within the framework of the Enterprise Architecture I have previously discussed. That system will be part of an integrated, whole solution to the needs of our veterans.

Question 21b. Despite this testimony just a few weeks ago, you now propose a specific increase in VBA spending to address the issue of backlogs in VA's disability claims process. Would any of this funding be directed to information technology resources? If so, are you now adopting a plan to expend funds on such resources in accordance with a plan that, just a few weeks ago, you had criticized?

Answer. As I have previously stated, there will be no spending on new IT initiatives until a comprehensive, integrated IT Enterprise Architecture has been adopted.

Question 22a. The Veterans Benefits Administration (VBA) faces both short-term and long-term challenges in addressing the backlog of pending veterans claims for benefits. This budget proposal requests a total increase of only $1.0 billion—the lion's share of which will go, I presume, to medical care spending increases. How much of this funding increase will go to the Veterans Benefits Administration?

Answer. Total discretionary funding (GOE Budget Authority and Credit Reform Budget Authority) of $1,116,300,000 and 12,019 FTE reflect increases of $133,531,000 and 904 FTE.

Question 22b. You stated during the confirmation process that the adjudication backlog was the biggest challenge that you face. Does this budget proposal address that challenge?

Answer. Yes. Compensation and Pension (C&P) receives the lion's share of total obligations ($775.5 million), as well as the largest increase in direct FTE (863). With these resources, VBA will be better able to counteract the increases in workload generated from recently enacted Duty to Assist legislation and regulations regarding diabetes. The strategy calls for these specialized claims to be worked in newly formed SDN Service Centers. The Centers are composed of Veterans Service Representatives (VSRs) and Rating VSRs, with lower graded employees to perform data entry and reemployed annuitants to guide and mentor trainees.

The challenges facing VBA, specifically improving accuracy and timeliness in claims processing, will not be solved overnight. VBA has developed an aggressive plan contained in this budget request to continue progress in many areas while mitigating the effects of recent legislative and regulatory actions. To the extent that resources become available in FY 2002, VBA's new initiatives and additional FTE will reinvigorate and improve the current process. This task is not insurmountable. VBA is poised to implement the Secretary's commitment to processing claims in 100 days with a manageable pending workload of 250,000 by summer 2003 and that is achievable with hard work, determination, ingenuity and a deliberate emphasis on accuracy.

Question 22c. I understand that one of VA's most significant longer-term challenges is the issue of the impending retirement of VBA's most experienced adjudicators. Does this proposal address that challenge?

Answer. VBA has recognized the need to hire and train new personnel as increasing numbers of employees become eligible to retire, We have included a request for 485 FTE in FY 2000, 243 additional FTE in FY 2001, as well as reprogramming from other areas in order to increase C&P direct FTE. We believe that the additional 863 FTE requested for FY 2002 mainly associated with the recently enacted legislation and regulations, will help prevent a skills gap as VBA experiences increased attrition rates in the next several years. As the workload generated by Duty to Assist legislation and diabetes regulations becomes more manageable, VBA envisions assigning these specialized VSRs and RVSRs to broader claims work.

Question 23. In each off the past three budget cycles, VA has requested—and has received—funding to address its 1998 estimate that 255 of compensation and pension "decision makers" would retire by fiscal year 2004. VA's Under Secretary for Benefits testified last July that fiscal year 2002 would be the last year funding would be requested for "succession planning" purposes. In your view, is this still the case? How many experienced decision makers have retired already.

Answer. The FY 2002 Budget request does not include a "Succession Planning FTE Initiative." However, we believe that the additional 863 FTE mainly associated with the recently enacted legislation and regulations will go a long way toward precluding a skills gap as VBA experiences increased attrition rates in the near future. As the workload generated by Duty to Assist legislation and Diabetes regulations becomes more manageable, VBA envisions assigning these specialized VSR's and RVSR's to broader claims work. VBA still maintains the need to hire and train now to prepare for heavy attrition losses due to retirements. Due to aggressively pursuing this issue, VBA has been able to plan ahead for this inevitable wave of retirements. No further succession planning FTE requests beyond FY 2002 are planned at this time. Since 1998, VBA has lost approximately 900 decision makers.

Question 24. While improvements have been made in recent years, it takes roughly two years for an appeal to be resolved once a veteran files a Notice of Disagreement. What is your assessment of the staffing needs within the Board of Veterans Appeals to address the appeals backlog and the two-year wait for final appeals resolution? Does the budget reflect funding levels consistent with your assessment?

Answer. Since 1998, the Department has reported on "appeals resolution time." Appeals resolution time measures the time from the receipt of the Notice of Dis-

agreement (NOD) to the issuance of a final decision, which could include a decision by the regional office granting benefits. (A remand by the Board of Veterans' Appeals is not a final decision.) As such, it is a combined measure of timeliness of both the Board and the Veterans Benefits Administration (VBA). To achieve meaningful improvement in this timeliness measure, VA must optimally manage appeals workloads both at the Board and in regional offices and balance resources accordingly.

Appeals resolution time has been steadily decreasing, from 745 days in 1999 to 682 days in FY 2000. We currently project 650 days for FY 2001 and 590 days for FY 2002. While additional improvements must be made to achieve VA's appeals resolution time goal of 365 days, we believe this budget reflects the appropriate balance of resource levels for both the Board and VBA.

Question 25. As you know, the Committee has worked hard to increase Montgomery GI Bill (MGIB) benefits over the past two Congresses, and we have achieved success: an increase of 87 percent in the maximum monthly payout under MGIB. Do you recommend that the Congress enact further increases in MGIB benefits?

Answer. The President's Budget includes the annual cost-of-living increase for education benefits for veterans and service members, but does not include an additional benefit increase. The Administration fully supports these benefits and is evaluating how to continue to improve them. Consistent with MGIB's mission, the Administration will work to strike the appropriate balance between improving veterans' readjustment to civilian life and enhancing military recruitment and retention.

Question 26. Does this proposed budget address expected workload increases in VBA's education service due to recent increases in basic benefits under MGIB? If so, how?

Answer. The Tuition Assistance Top Up legislation, effective October 30, 2000, is expected to create 161,000 new claimants in FY 2001 and 214,000 additional claimants in FY 2002. Legislation allowing for payment of Licensure and Certification exams became effective March 1, 2001. We anticipate this legislation to generate 25,000 new claimants for FY 2001 and 100,000 additional claimants in FY 2002. These provisions could dramatically affect workload and our ability to process claims in a timely and effective manner.

VBA is planning to combat the increased workload through increased staffing for FY 2002, overtime usage, and the use of Virtual Help Teams. In addition, the current benefits delivery system, which cannot efficiently process the new workload, will undergo programming modifications. However, systems changes are long-term solutions and will not have a positive impact by 2002. The proposed budget has money to enable us to do all these things.

We have already started to address the increased workload in the current fiscal year. First, 25 additional FTE were allocated in the fall, 40 FTE were earmarked in December 2000, and 60 more FTE were allotted to Education in February 2001. Seasonal employees will constitute some portion of the 125 additional FTE because they can be used effectively during critical periods and make a dramatic impact on workload. The goal is that the additional resources for increased staffing in Education will be a top priority for the remainder of FY 2001, as well as FY 2002.

Second, overtime money will continue to be committed as needed during peak enrollment periods and to combat increased workload from new legislation. More than $300,000 has been used so far this fiscal year. In addition, during the workload crisis in fall 2000, mandatory overtime was implemented at the four Regional Processing Offices (RPOs) and will be used as needed to control cyclical workloads and increased workload due to new legislation.

Third, new ways of processing claims were tried and tested in fall 2000. With technology enhancements, RPOs were able to go beyond normal help teams and use Virtual Help Teams by pointing workstations towards other RPOs. The electronic environment puts all pertinent information related to a claim at one's fingertips, regardless of location. This allows personnel to process claims for another station without having to be on site physically, thus eliminating travel costs. In addition, virtual brokering work relieves the burden of having to ship claims to another office as well as eliminating the potential loss of claims in the mail. Because RPO workload peaks vary among offices, Virtual brokering can be used to manage part of the increase in workload.

Question 27. The President's budget recommends that VA's vendee loan program be eliminated. Why? How would elimination of this program save VA money?

Answer. The vendee home loan program, which is a non-veteran program, interacts with several accounts (saving money in one account and costing money in another). While vendee loans allow the Department to sell properties faster and at higher prices, thus reducing VA's cost of providing veterans with guaranteed loans, the cost of offering vendee loans to the general public is not offset by this reduction.

Past cost estimates did not formally score all the components and interactions between these accounts. OMB and VA recently completed this complex scoring, which takes into consideration all of the components and interactions, and determined that the elimination of the vendee loan program will have a net savings of $226.7 million over the next ten years.

Question 28. Do you think VA will be able to "unload" excess properties-particularly in depressed areas and during "bad" times—if VA ceases financing purchasers? If VA cannot sell its properties because it is unable to finance purchasers, how will the Government have saved money by continuing to hold onto distressed properties that VA cannot sell?

Answer. It is possible, if not probable, that there would be a build-up of property inventory in areas with distressed real estate markets, with or without the vendee loan program. In the past, the vendee loan financing tool has been very beneficial in holding inventory levels down. However, our ten-year savings estimate ($226.7 million) takes into account our best economic and property inventory assumptions.

Question 29. What does the Administration's budget propose for the administration, operation, and maintenance of the National Cemetery Administration's burial service and programs?

Answer. The National Cemetery Administration (NCA) appropriation funds the operation and maintenance of VA's 19 national cemeteries. A total of $121.2 million and 1,499 FTE are requested for 2002. This is an increase of $11.3 million and 33 FTE over the 2001 current estimate level.

The budget request includes an increase of $5 million for the National Shrine Commitment. This increase is in addition to the $5 million provided for this initiative in the 2001 appropriation, bringing the total funding for the program in 2002 to $10 million. The National Shrine Commitment is a program to improve the appearance of burial grounds and historic structures required for NCA to fulfill its commitment to maintain our national cemeteries as national shrines. The resources provided in the 2001 appropriation and requested in this budget will be used to address currently identified deficiencies in the appearance of a number of headstones and markers and the condition of some gravesites. The VA national cemeteries continue to experience an increase in the number of gravesites and developed acres that must be maintained. This budget requests $1.6 million to address an increase of 67,700 gravesites, and an additional 217 acres of developed land in 2002 that will require maintenance.

As the rate of death of the veteran population continues to increase, the annual number of interments at VA national cemeteries continues to increase, In order to maintain the quality of our interment service, this budget requests $1.1 million and 25 FTE to address the 3.1 percent increase in projected interments in 2002. This increase in veteran deaths will also result in an increase in the number of headstones and markers ordered, not only for veterans buried in national cemeteries, but also state veterans' cemeteries and private cemeteries. This budget requests an additional $51,000 and one IFTE to maintain the efficiency of the headstone and marker ordering process with the projected increase of over six thousand orders in 2002.

NCA continues to expand the capacity and improve the infrastructure of existing cemeteries to ensure that they continue to meet the needs of veterans and other stakeholders. NCA will add four IFTE to perform in-house architectural and engineering efforts and construction contract support that were previously performed by the Veterans Health Administration (VHA). These will be funded within existing resources by ending the reimbursement to VHA for these services. An additional $241,000 is requested to support two more FTE for contracting support and one FTE to establish the position of Information Technology Security Officer.

The 2002 budget request also includes an additional $3.3 million for federal pay raises and projected inflation.

Question 30. What is the status of each of the six cemeteries for which VA has received either design funding or full funding? What is the construction timetable for each of the cemeteries? Does the fiscal year 2002 budget request full construction funding for any national cemeteries?

Answer. The status of the efforts to establish six new national cemeteries is described below. Land has been acquired for the Ft. Sill, Oklahoma and Atlanta, Georgia areas. In addition, full construction funding was provided in the FY 2001 appropriation for the Ft. Sill location and full construction funding is requested in the FY 2002 President's budget for the Atlanta location. Progress in identifying and acquiring land for each of the remaining four locations is ongoing.

ATLANTA, GEORGIA—The Department has acquired an approximately 770-acre site in Cherokee County, north of Atlanta. Mr. Scott Hudgens, a World War II veteran, donated this site. A contract for developing the cemetery's Master Plan is scheduled

to be awarded this summer. The 2002 President's Budget requests $28.2 million for Phase I construction of this new national cemetery. If these requested funds are appropriated, the construction contract award is expected in August 2002, and completion of the construction is expected in May 2004.

DETROIT, MICHIGAN—Representatives of the National Cemetery Administration (NCA) actively worked with the Michigan Veterans Affairs Directorate, area real estate agents, and the Veterans Benefits Administration's (VBA) Loan Guaranty officials at the Detroit VA Regional Office to identify available property for evaluation as a new national cemetery. Eight potential parcels of land were identified for further consideration. Pending full evaluation of the characteristics of each site, the best sites for environmental assessment will be selected. After all environmental assessments are completed, a recommendation for final selection will be forwarded to the Secretary of Veterans Affairs. An appraisal of the preferred site will also be conducted.

The 2002 President's Budget includes $18 million to be available for the purchase of land for new cemeteries in the vicinity of Detroit, Michigan; Pittsburgh, Pennsylvania; and Sacramento, California.

MIAMI, FLORIDA—Representatives of the National Cemetery Administration (NCA) and the Florida Department of Veterans Affairs visited eleven prospective sites in south Florida and developed a recommendation of "top sites" for further consideration. The Acting Under Secretary for Memorial Affairs and the Director, Florida Department of Veterans Affairs visited the top three sites in August 2000. As a result, two top sites were selected. Both sites are located in Palm Beach County.

In October 2000, URS, Greiner, Woodward, and Clyde began conducting the environmental assessment process on each of the two top sites to assess the impacts of developing the land for use as a cemetery. Subsequently, the owner of one site removed it from consideration. The environmental assessment is being completed for the remaining location, which is near the West Palm Beach VA Medical Center. Very recently the EA consultant has identified two factors that will require further investigation. Realizing the negative potential of these findings, NCA is directing the EA consultant to expand their review to two additional sites that had been identified during initial site evaluation visits.

After all environmental assessments are completed, a recommendation for final selection will be forwarded to the Secretary of Veterans Affairs. An appraisal of the preferred site will also be conducted.

The 2001 appropriation contained $15 million for land acquisition, and the 2002 President's Budget requests Design Funding for the preparation of Construction Documents.

OKLAHOMA CITY, OKLAHOMA—The National Cemetery Administration (NCA) anticipates that a construction contract will be awarded in order for construction to begin before the end of 2001. NCA's goal is to complete construction in the fall of 2003. Design is being made for a "fast track" section that will permit interments to begin prior to full completion of all construction activities at the new cemetery. NCA projects that the "fast track" section will be available for burials in the fall of 2001.

The 2001 appropriation included $12 million for construction- All Phase I development costs are fully funded.

PITTSBURGH, PENNSYLVANIA—The Governor of Pennsylvania established a Cemetery Site Selection Committee to serve as a primary evaluation mechanism for locating sites and scheduling site visits. The National Cemetery Administration (NCA) staff visited Pittsburgh during June 2000 to meet with the State's Cemetery Site Selection Committee. NCA staff toured eleven proposed sites. In October 2000, the Under Secretary for Memorial Affairs toured the three top sites. Based upon these visits, the Under Secretary identified the Morgan Farms site, 15 miles southwest of Pittsburgh, as the most desirable and feasible location. The Morgan Farms location was also the preferred site named in the Cemetery Site Selection Committee's report that was submitted to the Pennsylvania House of Representatives.

A contract for an environmental assessment of the Morgan Farms site was awarded in December 2000 and the final report is expected by May 2001. An appraisal of the preferred site will be undertaken as a part of the environmental assessment contract. If the site is purchased, NCA anticipates that a contract for master planning will be awarded in the fall of 2001.

The 2002 President's Budget includes $18 million to be available for the purchase of land for new cemeteries in the vicinity of Detroit, Michigan; Pittsburgh, Pennsylvania; and Sacramento, California.

SACRAMENTO, CALIFORNIA—The National Cemetery Administration (NCA) officials worked closely with representatives of the California Department of Veterans Affairs and local realtors to identify suitable locations for consideration as a new na-

tional cemetery. A joint VA/State site evaluation team visited nine sites in the Sacramento area during October 2000. Several potential cemetery sites were identified.

NCA continues to analyze each site's characteristics. Pending full evaluation of each site the best sites for environmental assessment will be selected. After all environmental assessments are completed, a recommendation for final selection will be forwarded to the Secretary of Veterans Affairs. An appraisal of the preferred site will also be conducted.

The 2002 President's Budget includes $18 million to be available for the purchase of land for new cemeteries in the vicinity of Detroit, Michigan, Pittsburgh, Pennsylvania; and Sacramento, California.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BEN NIGHTHORSE CAMPBELL TO ANTHONY J. PRINCIPI

Question 1. I know you are supportive of innovative and creative ideas for modernizing and streamlining the health care services provided to our veterans. In my home State of Colorado, there is the unique opportunity to build new facilities on the old Fitzsimons site that would be shared by both the Veterans Administration Medical Center (VAMC) and the University of Colorado Hospital (UCH). I understand a joint study shows this sharing of location and facilities could save the VA Medical Center one billion dollars over 20 years. Veterans in Colorado are generally supportive of this move. How would you see such collaboration fitting in with the mission and priorities of the VA?

Answer. In 1999, the University of Colorado Health Sciences Center (UCHSC) and University of Colorado Hospital (UCH) decided to relocate to the former Fitzsimons Army Base. The entire campus of the UCHSC, including UCH, will be relocated over the next several years. It will be part of a larger complex that is expected to draw world-class research and development, talent, and resources. All of this will have great impact upon the quality, timeliness, and cost of care at the Denver VAMC, which is directly adjacent to the current campus and about eight miles away from the Fitzsimons site.

As a result of this decision to relocate, representatives from the VA Rocky Mountain Network (VISN 19), the Denver VA Medical Center (VAMC), UCHSC, UCH, and veterans service organizations began meeting to assess future collaborative arrangements between VA and the UCHSC and UCH. A subcommittee was charged with developing a preliminary concept for a collaboration of the Denver VAMC with UCH at Fitzsimons. A consultant was hired to develop a conceptual plan to propose several options for a possible relocation of the Denver VAMC.

The consultant's report included options that ranged from building a new VA hospital totally separated from the UCH to full integration of the VAMC and UCH. One option also provided for integrating some services between the two organizations. The report indicated that VA might save as much as one billion dollars over a twenty-year period due to reduced maintenance, remodeling, and replacement costs, if colocation was accomplished with the University at Fitzsimons. Co-location could facilitate continued recruitment and retention of clinicians with faculty appointments at the University, rather than requiring a commute to the current VAMC site.

VA and University of Colorado planning groups are continuing to discuss the options proposed by the consultant. These are early discussions and no proposal has been submitted to VA Central Office for review. Initial indications are that the University of Colorado will ask VA for a decision on relocating to the Fitzsimons campus by July 2003. The next step is to determine which, if any, of the options outlined in the consultant's report is a better way to provide high-quality health care to veterans. In addition, the Department will be performing Capital Asset Realignment for Enhanced Services (CARES) studies of this area in the near future. If it is determined to be in the best interest of VA that the Denver VAMC be relocated to the Fitzsimons campus, then a further decision will be needed on the type and extent of integration with UCH.

Question 2. Is there a process in place for a private property owner to donate his/her land to the Department of Veterans Affairs, some other government entity, or non-profit organization for the express purpose of establishing a local, State or federal military cemetery? If so, please provide the Committee with a brief outline of the process. If such donations are allowed, are they considered deductible for tax purposes?

Answer. The concentration of veterans in any particular geographic area, and their need for a national cemetery, is a primary consideration in the selection or acceptance of land. The Federal Government is authorized to accept donations of land from individuals to be used for creation or expansion of national cemeteries.

The Federal Government cannot accept real property for the purpose of establishing local or State cemeteries. The site of the pending Atlanta-area national cemetery is a donation from a private individual, and the site of the San Joaquin Valley National Cemetery in California is formed from a private donation. Many of our existing cemeteries have expanded on land donated by adjacent property owners (Fort Smith N/C (AR), Camp Butler N/C (IL), Port Hudson N/C (LA)). The acceptance of land to create a State veterans' cemetery would be the responsibility of the respective State government, subject to any rules or criteria that the State may require.

The process by which the Department of Veterans Affairs (VA) may accept a donation of land is relatively simple, yet subject to legal review in order to protect the interest of the Government. A basic "Offer to Donate Real Property" form is completed and signed by the owner; authorization to proceed with acceptance is signed by the Secretary; a survey and title search are conducted by the Government; an environmental assessment is conducted by the Government in compliance with National Environmental Protection Act (NEPA) provisions; and, if all legal aspects are in proper order, closing is held. Most States exercise these same or similar procedures for accepting donated land.

VA defers to the Internal Revenue Service (IRS) on the issue of whether donations of land for national cemeteries are deductible for tax purposes. The IRS is responsible for determining whether donations of real property are tax deductible under the Internal Revenue Code.

Question 3. Many service organizations have expressed interest in improving women's care in VA hospital—such as providing equipment and training staff to perform mammograms. How do you see the future of health care for women in the VA?

Answer. Women veterans are one of the fastest growing segments of the veteran population, second only to elderly veterans. In FY 2000, they comprised 5.5 percent of the total veteran population, an increase from 4.7 percent in FY 1997. Women veterans currently represent approximately 5 percent of all users of the VA health care system. The Veterans Health Administration (VHA) estimates that by 2010, women will comprise 10 percent of veterans utilizing VA health care services.

The needs of women veterans are often different than those of male veterans. In addition to access to primary care, medical subspecialty care, mental health services, and geriatric care, women veterans also require access to gynecological care and, for younger women, obstetric and infertility services. Maternity and infertility services, except invitro fertilization, are a part of VHA's uniform health care benefits package, which was published in October 1999, and makes the full spectrum of health care available to women veterans through VA. We will ensure that these programs remain available and expand in scope in order to accommodate the projected increase in women veterans using the VA health care system.

It is VHA policy that breast screening services be included as part of the complete primary care examination for women. VA facilities performing mammograms are required to be certified by the Food and Drug Administration (FDA) to provide screening and diagnostic services. When VA facilities have the necessary equipment and staff training, and do enough mammograms each year to be certified, they are encouraged to do so. When mammography services are obtained through contractual arrangements or sharing agreements, the referring VA facility must ensure that the provider has current accreditation and FDA certification.

Educational opportunities designed to develop clinical skills and knowledge for VA clinicians is available through traditional training programs. For example, the Annual Ambulatory Care Conference, to be held this year in San Diego from August 28 through 30, includes women's health topics such as cancer screening, breast disease, pregnancy care, and sexual trauma. Videotapes on these topics are available in the VA Medical Center libraries and local educational programs are held regularly. Veterans service organizations have cooperated with VA staff in developing women's health educational and training efforts in areas related to experiences specific to women veterans or to health care problems prevalent in the women veteran population, particularly sexual trauma. The Disabled American Veterans co-sponsored the National Summit on Women Veterans in June 2000, which was very useful in educating VA staff on the needs and views of women veterans.

To ensure that women veterans receive appropriate, timely, and compassionate health care, VHA established the Women Veterans Health Program (WVHP) in 1997. The program director is based in VHA Central Office in Washington, DC, and is assisted by four Deputy Field Directors. At the local medical facility level, Women Veterans Coordinators are responsible for coordinating health care services for women veterans.

In March 2000, VA's Under Secretary for Health requested the Women Veterans Health National Strategic Work Group to evaluate the current status of women's

health care in VA and make recommendations for strategic planning for women's health. The culmination of the work group activities will be a National Women Veterans Health Program Strategic Plan for FY 2002 through 2007. The plan is expected to be completed by October 2001.

Question 4. In the past, the Veterans Administration has seemed to ignore the grass roots input from veterans around the country concerning care and services they receive. What would be your position on forming a fact-finding commission that would go to areas of high concentrations of veterans to conduct town hall meetings where veterans' concerns could be aired?

Answer. VETERANS HEALTH ADMINISTRATION (VHA)—VHA has numerous mechanisms in place to seek input from both the veterans we serve and veterans service organizations (VSOs) at all levels. VHA uses this information to formulate policy and refine its services and program activities. We do not believe that a special "fact-finding commission" is needed at this time.

VHA's Veterans Integrated Service Networks (VISNs) and local medical facilities conduct frequent Town Hall meetings to allow veterans an opportunity to express their concerns and have these concerns addressed. These forums are used to explain changes in programs and services and to facilitate dialogue with veterans.

The VISNs have advisory groups, called Management Assistant Councils, whose members include VSOs, Congressional staffs, and other stakeholders. The groups meet regularly with directors and other facility and network officials. At headquarters, regional and local levels, VHA enjoys a collaborative working relationship with the VSOs, who very capably represent the views and interests of their members.

There are literally hundreds of community events across the country attended by VA leadership, including service chiefs, associate directors, and directors. At these events, VHA officials provide information to small and large groups of veterans on VHA services and answer questions on VA health care. VHA's directors and other senior officials also participate in panel discussions and question-and-answer opportunities at local, State, and national VSO conventions and meetings.

Veterans with Internet access have opportunities to ask questions and voice concerns through VA's interactive Web sites. These are routed, based on subject matter, to the appropriate individuals for a direct response to the veteran. Since January of this year, for example, VA's Office of Consumer Affairs has averaged about 400 Internet, phone, and letter inquiries per month, much of it health-care related.

Each VA medical center (VAMC) has a patient advocate office that can be used by veterans as a forum to air their concerns. Veterans are informed of the right to request Patient Advocate assistance through the distribution of patient rights brochures, Patient Advocate brochures, and posters and signs throughout the medical center. VAMC staff members are informed of the Patient Advocate Program through orientation meetings. Patients may contact the Patient Advocate in person, by phone, letter, or e-mail. A response to all patient complaints, with documentation of the resolution effort, occurs as soon as possible, but no longer than 7 days after the patient's complaint. Many complaints are resolved immediately.

VHA is committed to a process of continuous assessment of patient satisfaction. National Veteran Satisfaction Surveys are administered semi-annually by mail to a sample of veteran patients meeting qualifying factors in six different survey cohorts (ranked by size). The survey cohorts include Ambulatory Care, Inpatient Care, Gulf War, Prosthetics/Sensory Aids, Spinal Cord Injured, and Home Based Primary Care.

The standardized survey instrument, methods, and analyses support comparisons between facilities or VISNs, as well as comparisons of performance over time. These analyses help VHA managers, clinicians, and employees better understand veterans' perceptions and needs. The information provided by the surveys drives process improvement at all levels of the organization in support of VHA's strategic plan and service commitments. VHA is committed to surveying because we have learned that surveys are a valuable, systematic way of listening to the needs and concerns of Veterans.

The Office of Quality and Performance has developed a hand held electronic Patient Satisfaction Survey Toolkit. The Toolkit is designed to support field-based patient satisfaction survey initiatives. The Toolkit will greatly enhance the local facility's ability to gather real-time patient feedback data to support improvements of care delivery. The Toolkit is currently being pilot-tested at the VA medical centers in Columbia, SC, Durham, NC, Lexington, KY, Richmond, VA, and Valley Healthcare System, NY.

In an effort to provide services to homeless veterans, and in conjunction with many community agencies, VHA plays a major role in stand-downs. These one, two, and three-day events offer a variety of services: housing and shelter referrals, Social Security benefit counseling, Agent Orange information and counseling, mental

health and other health care services, and legal services. From November 1999 to December 2000, VA participated in 216 stand-downs and benefits assistance fairs in 47 States, the District of Columbia, and Puerto Rico. Nearly 36,000 veterans (including 1,573 women veterans), 4,225 spouses, and 1,576 children attended these events, received assistance, and were given the opportunity to speak with and express their interests and concerns to VA staff and volunteers.

VHA will continue to seek feedback and dialogues with veterans in each community it serves and with the organizations that represent them, both through new and current initiatives and through patient satisfaction surveys.

VETERANS BENEFITS ADMINISTRATION (VBA)—Many Regional Offices initiate and participate in a variety of forums to reach out into the veteran communities within their jurisdictions. They use these forums to provide information, to hear veterans' concerns, and to counsel veterans and receive claims applications. Regional Offices do hold Town Hall meetings. The Boise Regional Office conducted the most recent of these in April 2001.

VBA participates in VA initiatives such as stand-downs for homeless veterans and in health fairs held in a variety of community settings. Regional Offices participate in other types of community outreach as well, including information fairs held at local shopping malls. Another effective way Regional Offices receive veteran feedback is by participating in call-in radio programs. These programs offer veterans an opportunity to provide VA with their input on a broad range of issues. Each of these outreach efforts affords VBA with an opportunity to hear veterans' concerns.

Staffs at Regional Offices interact with VSOs in ways other than through daily contact in the Regional Offices. Regional Office staffs attend conventions and local meetings to interact not only with organization executives but also with local memberships. These are opportunities for VBA to provide information and receive feedback from the local veteran communities and from those who represent veterans in the local communities.

Outreach efforts such as these give VBA important information on services and benefits we are providing. These efforts can supplement, in a more current manner, the information and feedback that we receive through our customer surveys. VBA will continue to encourage these types of outreach activities in order to provide needed information and services to the community, as well as to gather information from veterans about their concerns.

National Cemetery Administration (NCA)—Collecting "voice of the veteran" feedback is an important component of NCA's customer satisfaction strategy. For many years NCA has used focus groups to gather first hand accounts about the level and quality of services provided by national cemeteries, as well as the expectations and preferences held by veterans regarding their national shrines. For example, NCA conducted focus groups with local VSOs, members of the veteran community at large, and their family members, and funeral homes prior to the opening of the four newest national cemeteries: Saratoga, New York, Abraham Lincoln (Chicago, Illinois); Ohio Western Reserve (Cleveland, Ohio), and Dallas–Fort Worth, Texas. These focus groups were used to ascertain the expectations, requirements, needs and hopes that veterans, their families and funeral professionals held for the new national cemetery being constructed in their area. Results of these sessions were shared with the local cemetery director and his/her staff as well as NCA senior leadership for potential changes or adaptations to plans for cemetery operations. As a follow up to the "Pre Opening" focus groups, NCA is in the process of planning and conducting "Post Opening" focus groups at these cemeteries, as a way to determine if NCA met the expectations and requirements of its customers. NCA anticipates utilizing this same strategy for the six new national cemeteries currently being developed a part of the implementation of the Veterans Millennium Health Care and Benefits Act of 1999.

Question 5. Recent actuarial records show that World War II veterans are dying at the rate of 1,000 per day, and other veterans at 586 per day. The existing State and federal veterans cemeteries are almost at capacity. The previous administration had selected sites and planned to build an additional six federal cemeteries. What would be your policy concerning adding more federal cemeteries and increasing the federally subsidized State veterans cemetery program?

Answer. Veterans cemeteries are solemn shrines to those who served their country in time of need. VA is keeping this promise to America's veterans to honor them with a final resting place and lasting memorials that commemorate their service to the Nation. VA is accomplishing its mission to provide burial space for veterans in three ways:

• Establishing new national cemeteries—The FY 2002 Budget includes $48 million for land acquisition, design, and construction of new cemeteries in Atlanta,

Georgia; Detroit, Michigan; Pittsburgh, Pennsylvania; Sacramento, California; and Miami, Florida.

• Expanding existing national cemeteries wherever and whenever possible—The President's FY 2002 budget includes $16 million to fund the expansion of existing cemeteries in Massachusetts and Washington.

• Helping States establish, expand, or improve State veterans cemeteries through the State Cemetery Grants Program—The FY 2002 budget includes $25 million for this program.

The majority of the Department's current national cemeteries are open with available unassigned gravesites for both casketed and cremated remains, many with capacity beyond the year 2030. NCA continually monitors the inventory of gravesites at the national cemeteries, and where appropriate, NCA attempts to acquire additional land to extend the service life of these cemeteries. In many other instances where cemeteries have, or will soon close, NCA works in partnership with the States to establish State veterans cemeteries to ensure that the veterans in that area continue to be served by a burial option.

NCA is projecting that the percent of veterans served by a burial option in a national or State veterans cemetery within a reasonable distance of their residence will increase from 76 percent in FY 2001 to 88 percent by FY 2006 with the opening of the six new national cemeteries and additional planned new State veterans cemeteries. At the end of 2001, of the 119 existing national cemeteries, 87 will have space for first interments, whether full-casket or cremated remains, to include either in-ground or in columbaria. The other 32 national cemeteries will have exhausted their space for first interments of full-casket or cremated remains and can only perform interments in the same gravesite as a previously deceased family member.

As you know, we are establishing new national cemeteries to serve veterans in the areas of Oklahoma City, Oklahoma, at Ft. Sill; Atlanta, Georgia; Detroit, Michigan; Miami, Florida; Pittsburgh, Pennsylvania; and Sacramento, California. Beyond the opening of these six new national cemeteries, section 613 of The Millennium Act directed that VA contract for an independent study to, among other things, identify those areas of the United States with the largest number of unserved veterans and identify the number of new cemeteries needed from 2005 to 2020. This study will guide us in the future as we strive to achieve our long-range goal of providing all eligible veterans reasonable access to a burial option.

Public Law 105–368, which provided for Federal participation of up to 100 percent for State cemetery grants, has effectively encouraged participation in the State Cemetery Grants Program. This program is an important part of our strategy for meeting the burial needs of our veterans. It is a successful program, and I support it wholeheartedly. In FY 2000, 43 operational State veterans cemeteries provided 14,354 burials to veterans and eligible family members. This figure represented a 7.7 percent increase over the previous year and accounted for approximately 15 percent of the total number of burials provided by VA national cemeteries and VA-assisted State cemeteries combined. VA will continue to work closely with the members of the National Association of State Directors of Veterans Affairs (NASDVA) to increase State participation in this program.

Response to Written Questions Submitted by Hon. John D. Rockefeller IV to Anthony J. Principi

GENERAL

Question 1. How will the $1 billion dollar increase for VA proposed in the President's budget be divided among the various elements in VA?

Answer. The attached table lists VA's discretionary program budget submission to Congress. The budget provides for $896 million in medical care and millennium collections. The millennium collections of $121 million (* below), which were not available in 2001, are now available in 2002 and are scored as mandatory.

Budget Authority Net Comparison of the FY 2002 Budget Request

[dollars in thousands]

Discretionary Programs	President's		
	FY 2001	Request	Difference
Medical Programs:			
Medical Care [1]	20,229,799	20,979,742	+749,943

Budget Authority Net Comparison of the FY 2002 Budget Request—Continued

[dollars in thousands]

Discretionary Programs	President's		
	FY 2001	Request	Difference
Medical Care Collections Fund	675,000	775,000	+100,000
Health Services Improvement Fund collections *	.....	121,000	+121,000
Subtotal, Medical Care	20,904,799	21,875,742	+970,943
Medical and Prosthetic Research	350,228	360,237	+10,009
MAMOE	61,780	67,628	+5,848
Total Medical Programs	21,316,807	22,303,607	4,986,800
Construction Programs:			
Construction, Major Projects	65,895	183,180	+117,285
Construction, Minor Projects	165,974	178,900	+12,926
Parking Revolving Fund	6,486	4,000	−2,486
Grants for State Extended Care	99,780	50,000	−49,780
Grants for State Cemeteries	24,945	25,000	+55
Total Construction Programs	363,080	441,080	+78,000
Veterans Benefits Administration:			
Education Loan Program Account (subsidy)	1	1	0
Vocational Rehabilitation Loans Program Account (subsidy)	52	72	+20
Total Veterans Benefits Administration	53	73	+20
General Operating Expenses & Misc.:			
Veterans Benefits Administration (GOE only) [1]	825,832	955,352	+129,520
Veterans Housing Benefits Program Fund Program Account	157,239	161,483	+4,244
Proposed legislation	.....	−1,400	−1,400
Native American Veterans Housing Loan Program Account	514	527	+13
Education Loan Program Account	220	64	−156
Vocational Rehabilitation Program Account	431	274	−157
Subtotal, Credit Reform	158,404	160,948	+2,544
Total, Veterans Benefits Administration w/Credit	984,236	1,116,300	+132,064
General Administration [1]	226,521	239,479	+12,958
Credit Reform (General Counsel)			
Veterans Housing Benefits Program Fund Program Account	4,404	4,414	+10
Native American Veterans Housing Loan Program Account	17	17	0
Subtotal, Credit Reform (General Counsel)	4,421	4,431	+10
Subtotal, General Administration w/Credit	230,942	243,910	+12,968
Total General Operating Expenses w/out Credit	1,052,353	1,194,831	+142,478
Total, Credit Reform—Administrative	162,825	165,379	+2,554
National Cemetery Administration [1]	109,045	121,169	+12,124
Office of Inspector General [1]	46,284	48,308	+2,024
Total General Operating Expenses and Misc	1,370,507	1,529,687	+159,180
Total Discretionary with Collections (including HSI collections which are scored as mandatory)	23,050,447	24,274,447	1,224,000
Proprietary Receipts:			
Medical Care Collections Fund	−675,000	−775,000	−100,000
Veterans Health Service Improvement *	.....	−121,000	−121,000
Total Discretionary Programs	22,375,447	23,378,447	+1,003,000

[1] Excludes the transfers and reprogramming to General Operating Expenses—General Administration for the Office of Employment Discrimination Complaint Adjudication and the Office of Resolution Management activities in 2001. For 2002, VA is proposing that funding for these activities be handled on a reimbursable basis.

HEALTH CARE

Question 2. What more could be done if the VA health care account received an additional increase above what the President is requesting?

Answer. I believe that the President's budget request for VA health care is sufficient and supports the continuation and strengthening of very important health care initiatives impacting the health and well-being of veterans. As with the rest of the budget, details of VA health care appropriations and accounts were released on April 9,2001.

Question 3. Great progress has been made in expanding long-term care services to veterans-nursing home care for those with disabilities. rated 70 percent and higher, and non-institutional care for all enrollees. What is your view about including all long-term care services in the standard benefits package?

Answer. As authorized by the Veterans Millennium Health Care and Benefits Act, VA plans to add all non-institutional extended care services to the Medical Benefits Package, thus providing access to these services for enrollees. These high-priority, non-institutional extended care programs will join Home-Based Primary Care, Homemaker/Home Health Aide, and Hospice Care, in creating a comprehensive array of home and community-based care for enrolled veterans.

VA believes it is appropriate to keep nursing home and domiciliary eligibility separate from home and community-based care at this time. VA believes it can meet its mandate for nursing home and domiciliary care without including these services in the Medical Benefits Package. At the same time, VA expects to meet many of the transitional needs of veterans requiring nursing home care. VA is interested in fostering the idea of coordination of federal health benefits, and this may be especially beneficial in the area of long-term care.

Question 4. The current network structure has seen various forms. The networks were originally envisioned as small entities with managerial control over a group of hospitals. Today, networks are rather large operations, some of which have line control over hospital services. Are you confident that the network structure allows you to oversee health care operations and to make sure that your priorities—on quality and on access—are being met?

Answer. Perhaps the principal distinction between the VA health care system at the beginning of the last decade and today is the degree to which service delivery is integrated across discrete geographic areas. This has been, in large measure, the result of the network organizational structure adopted by the Veterans Health Administration (VHA) in the early 1990s. This model, now a hallmark of high performing private health care delivery systems, has been instrumental in VA's impressive progress in controlling costs and unnecessary utilization while dramatically improving service delivery, patient safety, and quality. These strides have allowed the VA health care system to emerge from the last decade as an acknowledged leader in the health care industry. Another principal strength of the Veterans Integrated Service Network (VISN) management structure is its operational ability to keep pace with a rapidly changing health care. environment. The VISN structure allows VHA to maximize policy oversight and compliance while maintaining the flexibility to respond to local health needs and stakeholders more quickly.

VA emphasizes managing health care versus managing facilities. Through a major transformation effort, VA has improved safety and quality of care, veteran satisfaction, enhanced veterans' access to care, reduced gaps and overlaps in services and reduced administrative overhead. It also emphasizes collaborations, with other federal agencies, academic affiliates, and community partners to achieve these goals.

As the Department continues to improve services for our Nation's veterans, we have imposed a number of requirements on the field, such as the need for each facility and Network to have dedicated information security officers and dedicated patient safety staff. Implementation of bar code medication administration, the emphasis on wafting times, clinical practice guidelines, and the increased reliance on the Institute for Healthcare Improvement principles to improve waiting times are issues discussed continuously in VHA, including a review during the Network Director quarterly performance reviews. I am paying close attention to waiting times for clinic appointments and pharmacy waiting times specifically and feel confident that the network directors will continue to make improvements in these areas.

Question 5. Despite the fact that GAO has not done an actual audit of VA's capital assets, many have been quick to cite GAO findings that VA is wasting a million dollars a day on its physical plant. What is your sense about how much of that $1 million is actually wasted (for example, heating an abandoned building), and how much is actually the cost of caring for patients?

Answer. GAO's $1 million per day estimate of the "cost of asset ownership" included a combination of indirect operating costs and fixed costs. Some of the costs

included in this estimate were administration, engineering, environmental, security, textile, food service, and capital investment in VHA's infrastructure. GAO stated that their basis for including all these activities was founded on OMB's definition of the cost of asset ownership: "the total of all costs incurred by the owners and users to obtain the benefits of a given acquisition." While VA agrees with GAO that these costs are, in fact, part of the total costs incurred by VA to obtain the benefit of our capital assets, this is entirely different from a concept of "waste." Many of the costs included in this estimate, such as utilities, food preparation, housekeeping services, textile management, and security, are essential elements for the delivery of patient care. VA does not believe that these essential indirect costs of patient care should be included as part of asset ownership costs in the context of this question. However, VA does expect to realize significant cost savings by investing resources in realigning VA's existing capital assets through the implementation of Capital Asset Realignment for Enhanced Services (CARES) options. These savings would be a result of reduced costs including direct, indirect, and operations and maintenance costs.

VA recognizes that there are efficiencies that can be achieved through possible integration and/or consolidation of facilities and services. VHA will carefully monitor maintenance and operation expenditures and significant efforts will be undertaken to reduce or eliminate unnecessary expenditures such as the cost of heating and maintaining vacant space as referenced in this question. CARES studies and identification of CARES options are needed to help VHA identify excess or underutilized capital and specific capital restructuring options to reduce the cost of asset ownership while simultaneously improving both access and quality of patient care.

Question 6a. The President's budget will likely contain proposals to manage the increase in demand for health care services. The data I have received indicates that less than 20 percent of the patients using the system are "higher income" veterans and that they use 6 percent of the resources. These numbers do not indicate to me that these veterans are seriously taxing the entire system. What is your view?

Answer. Your perceptions are a fair assessment of the utilization of priority 7 ("higher income") veterans. Our FY 2001 Enrollment Report shows that 21 percent of the users will be priority 7 veterans, and they will consume 9 percent of the resources equal to $1.6 billion. Data for FY 2000 show the average cost for a priority 7 veteran patient was $1,844, compared to $4,856 for all veteran patients. Sixty percent of the priority 7 veterans had annual patient costs of less than $1,000. Additionally, 23 percent of our priority 7 patients did not receive any prescription drug benefit from VHA.

Data from the FY 1999 and FY 2000 Enrollee Surveys show that "new" enrollees (i.e., those new to the system since enrollment began in FY 1999) do not rely as heavily on VA for their health care as do "past" enrollees, veterans who used VA anytime in the three years prior to enrollment (FY 1996–FY 1998). According to these surveys, "new" priority 7 enrollees received only 26 percent of their outpatient care and 7 percent of their inpatient care from VA. "Past" enrollees demonstrated higher reliance on VHA (up to 50 percent of their outpatient health care and 33 percent of their inpatient care).

Another issue that may affect priority 7 reliance on VA is the new TriCare for Life. Approximately 10 percent of priority. 7 enrollees are retired military, and half of these retirees are eligible for Medicare. With the introduction of TriCare for Life in October 2001, we estimate 15,000 of these enrollees will revert to reliance on TriCare and Medicare for most of their health care. Although not seriously taxing the system, the needs for specialty care and timely access for priorities 1 through 6 are concerns that will be considered when we make the enrollment decision for FY 2002.

Question 6b. Given that the proposed budget may not allow for continued enrollment of higher income veterans, how specifically will you reduce expenditures?

Answer. VA will continue to deliver high-quality and cost-effective health care to all veterans who enroll in the VA health care system to receive treatment. VA will operate within its appropriated medical care resources and continue to enhance those resources through effective collections of alternative revenues. The President's budget request reaffirms our primary commitment to provide high-quality medical care to veterans with service-connected disabilities or low income. The enrollment decision for FY 2002 is not scheduled until August. However, if availability of sufficient resources becomes an issue, different options will be considered, including limiting the enrollment of veterans in the "priority 7" enrollment priority. Increased copayments to recover more of the cost of care provided to veterans who are required to make co-payments for their VA health care will be implemented.

Question 7. We know that Medicare is failing beneficiaries when it comes to prescription drug coverage. Many would be surprised to learn that the VA health care

system is picking up the slack for the absence of drug coverage in Medicare. Indeed, large numbers of higher income veterans are now turning to the VA for drug coverage—and they only want the drug coverage. Do you believe VA should become a pharmacy—simply handing out the medications prescribed by non-VA doctors? If not, are there ways to better ensure that patients come for care, rather than just prescriptions?

Answer. I do not believe that VA should become a pharmacy. My belief is based on two important considerations. First, and most importantly, we believe that coordination of care by one provider is the cornerstone of high-quality health care. The accurate and up-to-date medical information that can only be provided by a single Primary Care provider (e.g., detailed medical history, complete medication use summary, and other pertinent clinical information) can reduce the risk that a course of treatment for an individual patient could lead to significant negative outcomes. Practicing, pharmacy in a fragmented, non-integrated manner is conducive to medication misadventures. It is VA's experience that providing pharmaceuticals as an integrated portion of VA's total health care benefit is both effective and efficient.

Second, dispensing prescriptions prescribed by non-VA doctors would dramatically increase VA's outlays for pharmaceuticals above today's 11 percent of the VA health care dollar. VA's current outlays for pharmaceuticals are below those of most managed-care organizations in the United States, largely for two reasons. First, the infrastructure is in place to develop and promulgate drug treatment guidelines and an effective National Formulary process. Second, and perhaps more importantly, VA's clinical pharmacists are members of primary care teams.

Question 8. Community-based outpatient clinics are terrific access points for our veterans. VA's own studies have found that care provided at CBOCs was similar to care provided at the hospitals. However, VA's own evaluations only looked at a small number of clinics, and still, found a lack of available information on clinics run by contractors. Are you confident that VA is able to manage the great proliferation of the clinics? And what is your sense of quality and timeliness concerns at these clinics?

Answer. VHA currently operates about 600 CBOCs and is in the process of opening close to 100 additional clinics. These CBOCs have been extremely successful, providing veterans with improved access to health care services.

VHA recently completed a 3-year study of new CBOCs, using a statistically significant sample of clinics. The study found that, overall, CBOCs have met their goals in improving access and providing quality care, consistent with that provided by VA hospitals. VHA studies have also shown that, regardless of contractual relationship, quality of care at the CBOC is comparable to care provided at the medical center clinics, with the exception of Ophthalmology. The finding regarding Ophthalmology was not surprising given that it is a specialty service and is more likely to be available at a VA medical center setting.

VHA monitors the quality of care at CBOCs through the Performance Measurement Program (PMP). CBOC patients are included in the random sampling of VHA cases that are selected for the External Peer Review Process (EPRP). Given the rapid growth in the numbers of CBOCs, VHA recently determined that it would increase the number of CBOC cases sampled through EPRP to provide better data about the quality of care provided at CBOCs.

Primary Care Clinics are the most frequently accessed clinics at the CBOCs. Average clinic wafting times at CBOCs nationwide are within 10-percent of the average waiting times at the parent facilities. VHA includes CBOC data in its assessment of performance relative to VHA's appointment waiting time goals, which are as follows:

- 90 percent of requested next available, non-urgent primary care appointments should be scheduled within 30 days.
- 90 percent of requested next available, non-urgent specialty (eye care, audiology, orthopedics, cardiology, urology) appointments should be scheduled within 30 days.

CBOCs are planned and managed by the local VISN, within the context of national policies and procedures. Decisions are made by the VISNs regarding the scope of CBOC services and mode of service delivery, based on local circumstances, including veteran demographics, availability of health care providers, demand for services, etc. We remain confident that we can continue to manage the proliferation of these clinics in this manner.

Question 9. The VA health care system—with its relatively closed system of care—could be a wonderful model for other systems. For example, the recent changes in law to provide all needed non-institutional long-term care would seem to provide a perfect opportunity for translation to other health care systems. VAs long-term care could be the model to prove something to the larger health care system, which is

so woefully inadequate when it comes to long-term rare. VA has also led the nation on assessing and treating pain for patients at the end of life. Do you see an opportunity for the VA to serve as a model for other health care systems? And if so, what will you do to make it happen?

Answer. VA does see the opportunity to serve as a, model to other health care systems for providing long-term care in an effective and efficient manner. Over the past several years, VA has developed and evaluated a number of geriatric and long-term care models, including geriatric evaluation and management, home-based primary care, and adult day health care. VA is also recognized as a national leader both in training geriatric clinicians for VA and other health care systems and in pain management at the end of life.

VA believes that the recent changes in law will facilitate our ability to better coordinate services for veterans who need long-term care. Specifically, VA plans to standardize the assessment of veterans referred for long-term care, in order to better target the services needed by patients over time. VA is also in the process of implementing three pilot projects for all-inclusive long-term care and one pilot project for assisted living, as authorized by law. VA health service research experts carefully designed the evaluation plans both for these pilots and for VA's overall experience in implementing the changes in the law. They will be collecting information on patient outcomes, utilization of services, and other variables over the next three years. The results of the evaluations will inform VA and other health care systems of the most effective and efficient ways of providing health care services to patients with long-term rare needs.

Question 10. Several grant programs for substance abuse and PTSD were recently awarded. Congress saw these grants as necessary to compensate, in some cases, for the elimination of inpatient programs. Before programs are eliminated-like inpatient substance abuse or PTSD-should VA be doing more to assess the potential effect? Do we at least need to know if a new type of care is as effective as the old one?

Answer. VHA Directive 99–030 requires that VISNs notify VHA Headquarters prior to making changes to mental health programs, including changes in mission, staffing, or bed levels. Proposals are reviewed by VHA's Mental Health Strategic Health Group (MHSHG) and forwarded to the Chief Network Officer. Approval must then be obtained from both the Chief Patient Care Services Officer and the Under Secretary for Health.

The Directive requires that all proposals include methods used to monitor the clinical impact of the change and an indication of outcome measures that will be used to assure continuation of high-quality care to affected patients. Proposals recommending bed closures must also include specific plans for assuring:

- the availability of intensive case management services and community-based services;
- increased access to outpatient follow-up care;
- uniform access to appropriate anti-psychotic or substance abuse therapies, including medications and psychotherapy;
- ready access to crisis management support comparable to that available to patients with other conditions or healthcare needs;
- continuity of care.

Given the social and economic burdens of many veterans who suffer from substance abuse or PTSD, the availability of the support and structure of inpatient/residential care may be important for them, not only in times of crisis but also when working through severe trauma or addiction issues. Therefore, VHA's MHSHG is engaged in continuous follow up on those programs that have changed to ensure that quality of care is maintained.

Question 11. On the subject of spinal cord injury centers, VA officials in the last. administration made a commitment to add beds and staff, returning the program to the capacity level mandated in the 1996 eligibility reform law. Still, compliance to the directives was spotty. What will you do to make sure that these staffing levels will be maintained? For example, does the budget contain the needed funds to bring the system up to current staffing levels?

Answer. VHA Directive 2000–022, issued in July 2000, identifies the number of available and staffed beds for each SCI Center, and articulates minimal staffing of SCI physicians, nurses, social workers, psychologists, and therapists. The Paralyzed Veterans of America and VA conduct monthly collaborative surveys to assess compliance with the directive. Although recruitment has been challenging, staffing and bed numbers are increasing. VHA has achieved nurse staffing for 91 percent of the beds expected within the SCI Centers. The goal is to fully staff 100 percent of the beds as specified in the directive. Network Directors are charged to devote adequate funding from existing resources to support this commitment.

Question 12. Many proposals to offer drug coverage to Medicare beneficiaries are tied to drug management and procurement. One tool VA uses to get these price breaks is the Federal Supply Schedule. What are your thoughts today about VA's price protection, in light of the fact that expanding the list of FSS purchasers will, in effect, raise the price of drugs for the VA?

Answer. I am concerned that VA prices will increase. VA's price protection applies to "covered" drugs (i.e., prescription drugs marketed under an NDA from the FDA and licensed biologicals), pursuant to P.L. 102–585 Sec. 603. Generic and even "covered" drugs that sell below the Federal price ceiling receive only temporary price protection. Increased access to new non-Government purchasers will increase the price of drugs as elements of the pharmaceutical industry seek to abandon their FSS contract or raise prices. Additional access to the FSS with anticipated per unit drug cost increases might decrease VA's capacity to provide health care to enrolled veterans. I believe efficient and effective drug coverage in other organizations is possible through other methods. Specifically, a private-sector pharmaceutical benefit management process, like the one used in VA's health care. system that recognizes all health care as local, can achieve effective pharmaceutical pricing and distribution without a link to FSS if properly organized.

Question 13. VA has done excellent work in treating veterans afflicted with Hepatitis C. Still, there is a sense that there are veterans with specific health concerns who have not sought treatment. Do you believe that VA is doing an adequate job of reaching out to veterans With specific health concerns, like Hepatitis C or AIDS? What more can be done to treat veterans with such health concerns, such as those with substance abuse problems, who may not be appropriate candidates for treatment right now?

Answer. To ensure that veterans with Hepatitis C receive state-of-art health care services and treatments, VA continues to expand and refine implementation of its Hepatitis C initiatives. Screening for Hepatitis C risk factors, followed by blood tests when appropriate, is performed throughout the VA health care system. For veterans who are Hepatitis C positive, treatment options are available when clinically appropriate for patients. All drugs and diagnostic tests approved for the treatment of Hepatitis C are available for use in VA. If treatment for Hepatitis C is not appropriate, veterans receive education and counseling in risk reduction and further transmission, as well as long-term monitoring or "watchful waiting." During FY 2000, 27,855 veterans had positive lab tests for Hepatitis C infection, and over 70,000 veterans with Hepatitis C infection received care in VA facilities. In order to reach out to veterans with specific concerns about Hepatitis C, VA has worked with the American Liver Foundation to develop an informational brochure to provide all veterans with important information about Hepatitis C risk factors, natural history, and testing. This brochure will be distributed to approximately 3.5 million veterans currently utilizing VA medical services.

In the arena of care for HIV-infected veterans, VHA has implemented policies and procedures for testing and counseling for HIV infection; updated and improved treatment guidelines for clinicians; conducted clinician education and training programs on HIV issues, HIV prevention screening, and risk reduction; and catalyzed HIV research conducted by VA scientists.

To address the specific health concerns of veterans with particular needs, a full range of health care services are offered in a variety of clinical settings. These settings include infectious disease clinics, homeless health care programs, Vet Centers, mental health programs, substance abuse programs, women veterans health programs, and primary health care settings. Provision of the most advanced diagnostic technology and treatment modalities, in conjunction with attention to the co-existing health and social problems of veterans with Hepatitis C or HIV/AIDS, remains a focus of VA.

Question 14. In pre-hearing questions before your confirmation hearing, I asked you about specific examples where sharing with DoD has been successful—both in terms of savings and improvements in the delivery of services. Your response was a less than impressive list of smaller projects. Do you think VA should be doing more to promote sharing? What kinds of projects do you envision?

Answer. VA and DoD have made a significant effort to establish a cooperative relationship with each other. VA's goal is to work with DoD to create a health care partnership that: (1) offers beneficiaries a seamless transition from one system to the other; (2) provides beneficiaries the highest possible return on the human and physical assets invested in the two systems; and (3) empowers each Department to fulfill its unique core missions. As described in the FY 2002 blueprint, the President will convene a Veterans Health Care Task Force. This group will be composed of officials and clinicians from VA and DoD, leaders of veterans and military service

organizations, and leaders in health care quality to make recommendations for improvement.

The Congressional Commission on Service Members and Veterans Transition Assistance Report made many recommendations regarding joint VA and DoD procurement, to include joint procurement of pharmaceuticals, medical/surgical supplies, and equipment. In response to that report, in December 1999, VA entered into a Memorandum of Agreement (MOA) with DoD to combine the purchasing power of the two Departments and eliminate redundancies. The MOA has three appendices. One deals with pharmaceuticals; the second encompasses medical and surgical supplies. The third appendix covers high-tech medical equipment.

While the negotiations have not always been easy, a major breakthrough occurred in late calendar year 2000 when DoD agreed to eliminate their Distribution and Pricing Agreements (DAPAs) for pharmaceuticals, and instead rely upon VA's Federal Supply Schedule (FSS) as the primary source for pharmaceuticals. As a result, DoD DAPAs were eliminated in January 2001, for all pharmaceuticals that are available in the FSS. This is a major step toward implementing the intent of the "Transition Commission."

A joint VA/DoD Data Management Group is developing data gathering and assessment plans for medical/surgical items. However, a major impediment toward standardizing and consolidating medical/surgical supply items is the lack of a Universal Product Numbering (UPN) system. VA is currently taking the lead by developing requisite cost-benefit analyses to support requiring Federal contractors to provide UPNs for medical/surgical commodities. This proposed requirement will undergo scrutiny at the Office of Management and Budget under the auspices of the Office of Information and Regulatory Affairs (OIRA) and will undergo public rulemaking.

As of March 1, 2001, there are 33 joint VA/DoD national committed use contracts for pharmaceuticals. The total estimated cost savings in FY 2000 for both Departments from these contracts were $42.5 million ($30.8 million for VA and $11.7 million for DoD). These savings were realized from 24 contracts. To date in FY 2001, eight additional national contracts have been awarded with discounts off the lowest FSS price, ranging from 0.19 percent to 53.75 percent. Once purchase/utilization data are available for these eight new contracts, cost savings data will be updated. Also, as of March 1, 2001, 24 additional joint contracts are pending award; four joint contracts were not awarded due to no cost savings afforded the government under the offers received. It is difficult to project how much additional savings will be achieved due to the dynamics of the pharmaceutical market place, i.e., branded products going generic and the clinical strategies employed by both Departments in the provision of their drug benefit. Many other drug categories will be considered for joint VA/DoD contracting activity as the contract period expires for their individual contracts.

The next major phase of the MOA implementation, converting Distribution and Pricing Agreements for medical/surgical products to FSS, and identifying joint opportunities for standardization that would promote even greater savings, is underway. VHA's Office, of Logistics will be working With the VA National Acquisition Center and respective DoD counterparts to facilitate shared acquisition strategies through the VA and DoD product standardization committees.

VA is pursuing many other sharing activities with DoD, e.g., the Government Computerized Patient Record, patient safety, depleted uranium research, the Military and Veterans Health Coordinating Board, and common treatment protocols for asthma, bad backs, and high cholesterol. VA remains committed to finding opportunities to share resources with DoD to expand quality services to veterans in a cost-effective manner.

Question 15. A number of new quality management programs have been developed since my staffs 1997 Staff Report on Quality Management. Do you believe that VA's quality management program is where it should be?

Answer. Quality management is never a completed task. However, VA's strides in quality and leadership in health rare quality management were specifically cited at the recent Institute of Medicine briefing accompanying the publication of their report, "Crossing the Quality Chasm."

The recommendations of your staff report were taken seriously. As recommended, the Office of Quality and Performance was created to specifically support the Under Secretary for Health's leadership and responsibility for the provision of consistent, high-quality care for veterans. Your report stressed the need for staff dedicated to quality management. We are pleased to report that a number of highly talented staff with excellent credentials have been recruited. All have significant experience and training in quality management, data analysis, clinical care, and health system operations.

VA is increasingly able to measure and report on quality. The ability to measure allows us to identify areas for improvement. It also allows recognition of areas where quality is excellent. In areas of preventive health, such as cancer screening, women's health care, and immunization, VA quality is not merely good but is increasingly surpassing government targets and private sector performance.

For example, improvements in pneumonia vaccination rates, from rates already above community performance, translate into important outcomes for veterans. Almost 4,000 lives have been saved because of improved pneumonia vaccination of patients with chronic lung disease alone.

Improvements are also occurring in areas of disease treatment. VA diabetes care programs are increasingly regarded as national models. Treatment of heart attack patients with aspirin and beta-blocker medications, and heart failure patients with ACE-inhibitor medications, is consistently better than reported elsewhere, including major teaching hospitals. This also translates into the very real outcome of lives saved.

Our "Quality Enhancement Research Initiatives," the QUERI programs, are specifically noted in the Institute of Medicine report as a model for translating the best research evidence into the best patient care. These "best practices" are supported through clinical practice guidelines and clinical reminders in the computerized patient record system. The combination of measurement and accountability provided through our Performance Measurement Program ensures that best practices are consistently provided.

Increasingly, VA's outcomes are validated in the most prestigious scientific journals. Dr. Laura Petersen described our quality in heart care in a recent New England Journal of Medicine article. The fact that these quality outcomes include all patients is also critical; a recent article in the Journal of the American Medical Association by Dr. Ashish Jha found that African Americans fared at least as well, if not better than, white patients in all of the conditions studied.

VA has also been recognized widely for its progressive approach to improving patient safety. Our National Center for Patient Safety is increasingly receiving more thorough "Root Cause Analyses" of both adverse events and close calls. Only through creating a culture in which people report freely will we learn, and avoid having the same situations recur. This process has revealed lessons valuable to both patients in VA and elsewhere, such as a programming defect in a widely used pacemaker.

VA is a complex organization. Quality management is not an afterthought or an ancillary program. It is embedded in our core processes. VHA's strategic goals establish a framework for measuring outcomes, and the performance management process requires accountability. In addition to the Office of Quality and Performance and the National Center for Patient Safety, the Office of the Medical Inspector is critical for investigating specific issues of concern. Program leaders in Patient Care Services are responsible for development of state-of-the-art clinical strategies for providing optimal care, and the network office must ensure the operational underpinnings for all of these activities. Each of these offices is represented on the Under Secretary's Coordinating Council for Quality and Safety. All leadership offices are represented on the Quality Management Integration Committee, which meets with field leadership and quality and safety managers via video teleconference each month for discussion of critical issues and to share best practices.

VA is also leading in terms of data-driven management of surgical outcomes. There is no more comprehensive and ongoing evaluation of surgical outcomes than VA's National Surgical Quality Improvement Program (NSQIP), or the parallel Continuous Improvement in Cardiac Surgery Program (CICSP). Continuous improvement in surgical morbidity and mortality has been sustained for more than a decade. Most remarkable, though, is that mortality rates in VA surgical programs are now consistently lower than would be expected on the basis of a patient's clinical risks. The American Surgical Association has cited the NSQIP model and is considering its use for surgeon re-credentialing.

While we have experienced many excellent outcomes, we have opportunities for improvement. We are working to ensure that care is not only of consistent, high quality, but that it is accessible. The 30/30/20 access goals are ambitious, yet appropriate. We will provide 90 percent of new primary care and specialty care visits within 30 days, and see 90 percent of patients within 20 minutes of their scheduled appointment time. Of course, patients with emergencies or urgent needs are seen as immediately as appropriate.

One of the key challenges for improving access and for monitoring and improving quality in VA is information management. Good data about clinical outcomes and core business processes is required. It should be obtained in a manner that is not intrusive to patient care or burdensome to the system, and in a manner that ex-

tends across all sites of care. An Information Letter has been released and additional policy is imminent which requires the provision of quality and safety data in all contracted care services. As well, we are enhancing mechanisms to better assess and report on care provided through our CBOCs. This includes use of electronic data where available and expansion of our External Peer Review Program (EPRP). Our information systems have improved and will continue to improve for the dual purposes of supporting and assuring high quality care.

In summary, improvement in quality and safety in VA are unmatched in scope, scale, or speed by any other health system. Increasingly, these improvements are recognized as model systems—by authoritative external appraisal. We are empathetic to any veteran whose care is poor, untimely, or dissatisfying. We accept and appreciate the tremendous responsibility of examining both individual breaches of quality or safety, as well as the need to ensure that we are a leader in assessing, supporting, and improving the delivery of consistent, high-quality care.

Toward identifying gaps in our processes, in information, and in best meeting the needs of our patients, VHA is embarking on a process of critical self-evaluation through Baldrige-based self-assessment. The reward of this effort is in better addressing these issues for the veterans we serve.

Question 16. Despite the recent improvements in developing better billing methods, I think there is general recognition that VA's collections efforts could be better. Given your familiarity with the collections effort, does it make sense to contract out the collections function?

Answer. We agree VA's medical care collections could be better. VA is committed to improving its revenue, collections, and billing procedures. We are open to the possibility of contracting out collection functions. In fact, VHA has a contract in place with a private vendor, TransWorld, Inc., to assist in the collections of third party claims to insurance carriers. Our experience with TransWorld has been quite favorable. We have invested slightly over $2 million and have recouped $57 million. We recognize that identifying and fixing process deficits must be done at the outset and we will continue to make these types of improvements. VA also needs to do a better job of identifying on insurance company bills which services we have provided. Finally, it is important that we better document services provided to veterans, and identify the insurance coverage that they hold. Perhaps the private sector can help with that process.

Currently, VA is running two pilots which contract for the collections and preparation of bills. Ongoing feedback from these pilots will be evaluated during the next year.

Question 17. In your testimony today, you indicated that in actuality, the proposed budget includes $1.2 billion in additional funds, including $200 million more in Medical Care Cost Fund collections. What is this increase predicated upon?

Answer. Two factors contribute to the estimated $200 million additional Medical Care Cost Fund collections. First, collections for the Medical Care Cost Funds are well above our FY 2001 goal. We are currently collecting at a rate of $57 million a month for the first five months. As you know, we now bill reasonable charges rather than a per them rate. This has greatly contributed to the increased collections, which we believe will continue in future years. The second factor is the increased revenue that we are anticipating from increased pharmacy co-payments as authorized by the Veterans Millennium Health Care and Benefits Act.

Question 18. Without a detailed budget request, it's difficult to discuss appropriate funding levels. This is especially true in the construction account. We do know, however, that we've seen a trend toward low requests for construction. What can we expect for this account? Are you willing to push for increased funding?

Answer. A system as large as the VA health care system cannot maintain quality and productivity over time without appropriate recognition of the need for infrastructure improvements. We believe that the VA health care system will require larger construction budget requests in the future for a variety of reasons: to correct seismic safety concerns, to provide for an orderly reinvestment in the system's infrastructure, and to implement CARES decisions.

As VHA proceeds through the CARES process, we expect to gain a more settled picture of the future need for VHA medical facilities. The first CARES studies will be done in 2001, and are expected to identify, among other things, options for reengineering VHA's physical infrastructure. Implementing these options will no doubt require major construction funding in many instances, but final decisions will come after careful consideration of the options available to meet VHA's health care missions. In the interim, the absence of completed CARES studies should not prohibit funding of a major project, but careful analysis is required before such a proposal can be made. For these reasons, I support the level of construction in the FY 2002 President's Budget.

Question 19. VA plans to reduce a hospital presence in some areas. At the same time, we are opening up more and more outpatient clinics. Both of these will naturally lead to reductions in training opportunities for medical residents. Do you believe that affiliations are important to VHA in the 21st century? If so, how can VA maintain the emphasis placed on teaching, given the budget request?

Answer. VA's medical school affiliations are essential to VA in the 215t century in accomplishing its missions. For over 50 years, VA has worked in partnership with this country's medical schools and other academic institutions to provide high quality health care to America's veterans, train physicians, and train other health care professionals to meet the patient care needs of VA and the Nation.

The academic mission in VA, as reflected in its academic affiliations, requires nurturing in these times of dramatic change in health rare. I will continue to meet regularly with the leadership of various clinical and academic components of VA to provide my commitment to their value to VA and veterans' health care. Just like VA health care, VA's academic affiliates are being impacted by the dramatic changes that are taking place in health care. We maintain active dialogues with our affiliates regarding how the affiliations can contribute substantively to improvement in many complex areas of change in health care. However, the rapidity of change requires extra efforts at communication and I am establishing a cadre of VA staff to lead a group to address VA academic relations. There are many issues to address, including expanding education and training opportunities in ambulatory care, primary care, specialty care, care for patients near the end of life, systematic approaches to improving quality of care, more effective inter-professional care and education, and more efficient use of scarce health care resources.

I believe VA.'s academic affiliations are robust and vigorous opportunities for providing the best approaches for continuous improvement of health care for veterans while contributing to strengthened academic medical institutions throughout the country. I also believe that we must work hard to keep them healthy even in times of budget constraints.

VETERANS BENEFITS

Question 20. What will the targeted amount for VBA buy for VBA—how many people? What kind of technology? What gains in processing and timeliness will be tied to this funding?

Answer. The $133.5 million requested increase over the FY 2001 enacted budget authority level, will provide for a net increase of 890 IFTE and $89.4 million in increased payroll. This increase includes 701 FTE to counter the expected increased workload from the recently enacted Duty to Assist legislation and new regulations regarding diabetes. New legislation impacting the education program requires 193 FTE for projected workload increases. Additional FTE for compensation and pension (C&P) initiatives, e.g., C&P Evaluation Redesign (CAPER)—10 FTE, Overseas Benefits Delivery at Discharge—12 FTE, and Systematic Individual Performance Assessment (SIPA)—80 FTE, are also funded. Decreases in information technology FTE and loan guaranty FTE associated with the proposed legislation eliminating the vendee loan program partially offset these increases.

The requested increase will also provide for continued and new investments in. technology, including Benefits Payment Replacement System (VETSNET Migration), Training and Performance Support Systems (TPSS), Virtual VA, Security and Infrastructure Protection (SIPO), Configuration Management, Operational Data Store, WINRS, EDI/EFT, and One VA Telephone Access. Information technology (IT) investments are requested only after they have passed a rigorous review from the Department's Capital Investment Board. The Veterans Benefits Administration (VBA) ensures solid IT investments that will deliver fully automated systems that are secure and which provide the access and ease of use that will ultimately produce the kind of accuracy, timeliness, and customer satisfaction VBA strives to achieve. However, there will be no spending on new IT initiatives until a comprehensive, integrated IT Enterprise Architecture has been adopted.

The increase over the FY 2001 enacted level will mitigate the performance setbacks we will encounter in claims processing and will be a first step to achieving the Department's goal of processing rating-related claims in 100 days by summer 2003.

Question 21. You have said that the budget includes a 13 percent increase in funding for VBA. Is this sufficient to achieve the goals you have set for VBA? If you had more money for VBA, what would you do with it?

Answer. VBA believes a 13 percent increase over the appropriated FY 2001 level represents a firm commitment and sufficient resources to achieving improvements in service and delivery of benefits. The Administration has designated claims proc-

essing as a Presidential initiative and has made funding for it a priority. This budget will allow VBA to hire 890 new employees, make IT investments as appropriate, and identify best practices as it strives to improve the service and delivery of benefits to veterans and their families. As you know, it takes 2 to 3 years for a newly hired claims adjudicator to become productive. Moreover, training, supervising, and mentoring new hires, which is necessary and invaluable, takes current staff away from their primary responsibility of processing claims. As such, the Administration's budget strikes the appropriate balance between investing in new employees and the immediate task of processing a backlog of claims.

Question 22. The Veterans Claims Adjudication Commission issued its report in December 1996. Have you reviewed it as part of your preparation to become Secretary or before issuing the Transition Commission Report? As Secretary, do you plan to pursue any of its findings?

Answer. While I am familiar with the report of the Veterans Claims Adjudication Commission in general, I did not review the report in preparation for assuming the responsibilities of Secretary. While the report was a portion of the body of knowledge available to the Congressional Commission on Servicemembers and Veterans Transition Assistance, it did not form the basis for the Commission's report. I would have to be briefed on the report before making any decisions as to the desirability of pursuing its findings.

Question 23. In 1991, Congress enacted legislation charging VA to contract with the National Academy of Sciences to periodically review the scientific literature to determine associations between health conditions and exposure to herbicides like Agent Orange. The NAS reports are intended to advise the Secretary in determining what conditions warrant presumptive service connection. In 1998 Congress mirrored this bill, providing a similar process for Gulf War veterans. However, veterans exposed to ionizing radiation have experienced a more piecemeal approach to compensation. In your view, is there value in crafting authority for atomic veterans similar to Agent Orange and Gulf War legislation?

Answer. We do not see much value in crafting authority for atomic veterans similar to the Agent Orange and Gulf War legislation. The primary reason is that many of the diseases that are believed to be radiogenic commonly appear only after exposure to relatively large doses of radiation, such as those used in cancer therapy. Applying the "positive association" standard does not resolve this issue.

Therefore, any approach that does not address the issue of radiation exposure levels would be vastly over-inclusive. If Congress were to draft such legislation, we would recommend that: (1) it not use the "positive association" standard, but rather a standard based on the probability of causation; (2) it be expanded to cover all veterans exposed to radiation during active military service, not just those present at Hiroshima, Nagasaki; or the atmospheric nuclear tests; and (3) it replace the presumptions established under Public Law 100–321.

Question 24a. Last year, we passed legislation reinstating VA's duty to assist veterans in developing their claims for benefits. I am very concerned about the impact that this legislation will have on veterans' claims. The U.S. Court of Appeals for Veterans Claims ruled last month, in Holliday, that it could not decide the applicability of this new law on pending claims until VA had addressed it first. This may result in remands back to the Board of Veterans' Appeals for virtually all claims.

A concerted, coordinated effort by VA will be needed to address this development. All elements within VA—the General Counsel, the Board, the Regional Offices, and the C&P Service—must work together. I am concerned that this may not be happening. What is VA's plan to tackle this? Please specify who is leading the effort.

Answer. *Veterans Benefits Administration (VBA) action—C&P Service:* The C&P Service has undertaken four main initiatives to address the impact of the Veterans Claims Assistance Act of 2000 (VCAA):

- It has made regulatory changes to implement the VCAA. These regulations were drafted in conjunction with input from the National Service Organizations, the Board of Veterans' Appeals, and VA General Counsel.
- The C&P Service has established interim claims processing procedures, incorporating the notice and development requirements of the VCAA. These interim procedures were conveyed to regional offices in several Fast Letters, conference calls, and via VA Internet sites. This interim guidance was reviewed for concurrence by VA General Counsel, who continues to review interim instructions disseminated via the Internet to field stations.
- The Compensation and Pension Service continues to meet regularly with members of the Board of Veterans' Appeals, General Counsel, and the Office of Field Operations to coordinate VCAA policy and procedures. Most recently, during the week of March 12, 2001, the Deputy Vice Chairman of the Board of Veterans' Appeals met with the Under Secretary for Benefits, the Deputy Under Secretary for Bene-

fits, and the Acting Director of the C&P Service to discuss additional steps to take to minimize the impact of VCAA on pending workload.

• The C&P Service has kept the National Service Organizations informed of VA's proposed policy and procedures to implement VCAA and has solicited input from these organizations. In addition, they were consulted while VA was drafting the proposed regulation. We look forward to their comments on the proposed regulation, which was published in the Federal Register on April 4, 2001.

Board of Veterans' Appeals (Board) action: The Board expects that the vast majority of cases pending at the Court of Appeals for Veterans Claims (CAVC) will be remanded so that they may be considered under the provisions of the VCAA. In the first five months of FY 2001 (October through February), we have received more that 1, 100 CAVC remands-an amount roughly equal to the total number of cases remanded to the Board during all of FY 1999 (1,412 cases) and FY 2000 (1,060 cases).

Although the Chairman has no authority to tell a Board member how to decide a case, the Board is not taking the position that these cases are all automatic remands to the regional office. Board members are reviewing each case on its merits based on the law currently available—statutes, court precedents, and precedent decisions of the General Counsel—to determine the proper outcome.

Among other things, there are appeals the Board can allow—26 percent in 2000—and it intends to allow them. In addition, there will be situations where it is clear that the regional office had, in fact, complied with the substance of the VCAA, and such cases can be decided on other grounds.

Nevertheless, it is likely that there will be a very high percentage of remands to regional offices. Indeed, we are seeing that already. The remand rate, which was 30 percent for FY 2000, was 56 percent for the month of February 2001.

The Board is also concerned about continuing to receive cases from the regional offices, as those offices struggle to comply with the new Duty to Assist features of the VCAA. Chairman Clark and Under Secretary Thompson are working together to ensure that the Board continues to receive appeals from regional offices.

Question 24b. What are the real costs of the new law? What portion of those costs are new staff time? Where do you plan to spend the money?

Answer. There are no significant benefits costs associated with the Veterans Claims Assistance Act of 2000. However, in developing the FY 2002 President's Budget, the C&P program gained 863 direct FTE. Of this total, 701 FTE, at a cost of $45.9 million, are slated for specialized work to counter the effects of the recently enacted Duty to Assist legislation and diabetes regulations. VBA has developed a strategy that calls for these claims to be worked in newly formed SDN service centers. The centers are composed of veterans service representatives (VSR) and rating VSRs, with lower graded employees to perform data entry and reemployed annuitants to guide and mentor trainees. While timeliness performance data for FY 2002 remains high, this plan presents a path toward achieving the Secretary's intent of processing claims in 100 days by March 2003. The Board does not anticipate any increased costs based on the VCAA.

Question 25. Last year, Congress also passed significant enhancements to the GI Bill—increasing the basic monthly benefit, paying for licensure and certification exams, and covering the remaining costs of servicemembers' courses after payment from DoD's tuition assistance. I have been told that these provisions are projected to double the workload of the education service, adding further stress on top of some recent increases in your backlog due to the imaging of claims at one of your four processing centers. What are you plans to address this new wave of claims?

Answer. The Tuition Assistance Top Off legislation, effective October 30, 2000, is expected to result in 161,000 new claimants in FY 2001 and 214,000 additional claimants in FY 2002. Legislation allowing for payment of Licensure and Certification exams became effective March 1, 2001. We anticipate this legislation to generate 25,000 new claimants for FY 2001 and 100,000 additional claimants in FY 2002. These provisions could dramatically affect workload and our ability to process claims in a timely and effective manner.

VBA is planning to address the increased workload through increased staffing for FY 2002, overtime usage, and the use of Virtual Help Teams. In addition, the current benefits delivery system, which cannot efficiently process the new workoad, will undergo programming modifications. However, systems changes are long-term solutions and will not have a positive impact by 2002. The proposed budget has money to enable us to do all these things.

We have already started to. address the increased workload in the current fiscal year. First, 25 additional FTE were allocated in the fall, 40 FTE were earmarked in December 2000, and 60 more FTE were allotted to Education in February 2001. Seasonal employees Will constitute some portion of the 125 additional FTE because

they can be used effectively during critical periods and make a dramatic impact on workload. The goal is that the additional resources for increased staffing in Education will be a top priority for the remainder of FY 2001, as well as FY 2002.

Second, overtime money will continue to be committed as needed during peak enrollment periods and to combat increased workload from new legislation. More than $300,000 has been used so far this fiscal year. In addition, during the workload crisis in fall 2000, mandatory overtime was implemented at the four Regional Processing Offices (RPOs) and will be used as needed to control cyclical workloads and increased workload due to new legislation.

Third, new ways of processing claims were tried and tested in fall 2000. With technology enhancements, RPOs were able to go beyond normal help teams and use Virtual Help Teams by pointing workstations towards other RPOs. The electronic environment puts all pertinent information related to a claim at one's fingertips, regardless of location. This allows personnel to process claims for another station without having to be on site physically, thus eliminating travel costs. In addition, virtual brokering work relieves the burden of having to ship claims to another office as well as eliminating the potential loss of claims in the mail. Because RPO workload peaks vary among offices, Virtual brokering can be used to manage part of the increase in workload.

Question 26. I understand that VBA is hiring additional, previously not programmed staff to address the growing backlog of claims. Does VA need a supplemental appropriation for the current fiscal year to pay for this additional staff? What will VBA do or what initiatives will be cut short if it does not receive a supplemental appropriation this year?

Answer. To address the significant increase in workload caused by recently enacted Duty to Assist and diabetes legislation, VBA has begun hiring new employees. As you know, it takes 2 to 3 years for a newly hired claims adjudicator to become fully productive. Consequently, the earlier they are hired, the earlier they can become productive. The Administration has identified resources within the FY 2001 budget to help accelerate the hiring of claims adjudicators and will be seeking transfer authority to move the resources into VBA. It is important to note that the Administration is not seeking new budgetary resources, but new authority necessary to effectuate the transfer.

Question 27. Sadly, our veterans population is aging rapidly, which means that we must focus on providing them with a place of honor to be laid to rest. Does the President's budget provide sufficient funds to move ahead on construction of the six new cemeteries authorized by Congress in 1999?

Answer. The status of the efforts to establish six new national cemeteries is described below. Land has been acquired for the Ft. Sill, Oklahoma and Atlanta, Georgia areas. In addition, full construction funding was provided in the FY 2001 appropriation for the Ft. Sill location and full construction funding is requested in the FY 2002 President's budget for the Atlanta location. Progress in identifying and acquiring land for each of the remaining four locations is ongoing.

Atlanta, Georgia—The Department has acquired an approximately 770-acre site in Cherokee County, north of Atlanta. Mr. Scoff Hudgens, a World War II veteran, donated this site. A contract for developing the cemetery's Master Plan is scheduled to be awarded this summer. The 2002 President's Budget requests $28.2 million for Phase I construction of this new national cemetery. If these requested funds are appropriated, the construction contract award is expected in August 2002, and completion of the construction is expected in May 2004.

Detroit, Michigan—Representatives of the National Cemetery Administration (NCA) actively worked with the Michigan Veterans Affairs Directorate, area real estate agents, and the Veterans Benefits Administration's (VBA) Loan Guaranty officials at the Detroit VA Regional Office to identify available property for evaluation as a new national cemetery. Eight potential parcels of land were identified for further consideration. Pending full evaluation of the characteristics of each site, the best sites for environmental assessment will be selected. After all environmental assessments are completed, a recommendation for final selection will be forwarded to the Secretary of Veterans Affairs. An appraisal of the preferred site will also be conducted.

The 2002 President's Budget includes $18 million to be available for the purchase of land for new cemeteries in the vicinity of Detroit, Michigan; Pittsburgh, Pennsylvania; and Sacramento, California.

Miami, Florida—Representatives of the National Cemetery Administration (NCA) and the Florida Department of Veterans Affairs visited eleven prospective sites in South Florida and developed a recommendation of "top sites" for further consideration. The Acting Under Secretary for Memorial Affairs and the Director, Florida

Department of Veterans Affairs visited the top three sites in August 2000. As a result, two top sites were selected. Both sites are located in Palm Beach County.

In October 2000, URS, Greiner, Woodward, and Clyde began conducting the environmental assessment process on each of the two top sites to assess the impacts of developing the land for use as a cemetery. Subsequently, the owner of one site removed it from consideration. The environmental assessment is being completed for the remaining location, which is near the West Palm Beach VA Medical Center. Very recently the EA consultant has identified two factors that will require further investigation. Realizing the negative potential of these findings, NCA is directing the EA consultant to expand their review to two additional sites that had been identified during initial site evaluation visits.

After all environmental assessments are completed, a recommendation for final selection will be forwarded to the Secretary of Veterans Affairs. An appraisal of the preferred site will also be conducted.

The 2001 appropriation contained $15 million for land acquisition, and the 2002 President's Budget requests Design Funding for the preparation of Construction Documents.

Oklahoma City, Oklahoma—The National Cemetery Administration (NCA) anticipates that a construction contract will be awarded in order for construction to begin before the end of 2001. NCA's goal is to complete construction in the fall of 2003. Design is being made for a "fast track" section that will permit interments to begin prior to full completion of all construction activities at the new cemetery. NCA projects that the "fast track" section will be available for burials in the fall of 2001.

The 2001 appropriation included $12 million for construction. All Phase I development costs are fully funded.

Pittsburgh, Pennsylvania—The Governor of Pennsylvania established a Cemetery Site Selection Committee to serve as a primary evaluation mechanism for locating, sites and scheduling site visits. The National Cemetery Administration (NCA) staff visited Pittsburgh during June 2000 to meet With the State's Cemetery Site Selection Committee. NCA staff toured eleven proposed sites. In October 2000, the Under Secretary for Memorial Affairs toured the three top sites. Based upon these visits, the Under Secretary identified the Morgan Farms site, 15 miles southwest of Pittsburgh, as the most desirable and feasible location. The Morgan Farms location was also the preferred site named in the Cemetery Site Selection Committee's report that was submitted to the Pennsylvania House of Representatives.

A contract for an environmental assessment of the Morgan Farms site was awarded in December 2000 and the final report is expected by May 2001. An appraisal of the preferred site will be undertaken as a part of the environmental assessment contract. If the site is purchased, NCA anticipates that a contract for master planning will be awarded in the fall of 2001.

The 2002 President's Budget includes $18 million to be available for the purchase of land for new cemeteries in the vicinity of Detroit, Michigan; Pittsburgh, Pennsylvania; and Sacramento, California.

Sacramento, California—The National Cemetery Administration (NCA) officials worked closely with representatives of the California Department of Veterans Affairs and local realtors to identify suitable locations for consideration as a new national cemetery. A joint VA/State site evaluation team visited nine sites in the Sacramento area during October 2000. Several potential cemetery sites were identified.

NCA continues to analyze each site's characteristics. Pending full evaluation of each site the best sites for environmental assessment will be selected. After all environmental assessments are completed, a recommendation for final selection will be forwarded to the Secretary of Veterans Affairs. An appraisal of the preferred site will also be conducted.

The 2002 President's Budget includes $18 million to be available for the purchase of land for new cemeteries in the vicinity of Detroit, Michigan; Pittsburgh, Pennsylvania; and Sacramento, California.

Question 28. VA is long overdue in its efforts to deal in a more coherent, uniform basis with the U.S. Court of Appeals for Veterans Claims. Decisions are not properly disseminated; litigation positions are inconsistent with practice in the field. Who leads the overall effort to interpret the Court's rulings, to disseminate that information, and to monitor compliance with the Court's rulings?

Answer. Over time, a multi-tiered system for analyzing and disseminating Court decisions has evolved at VA. It involves the Office of General Counsel (OGC), the Board of Veterans' Appeals (BVA), and the Compensation and Pension (C&P) Service.

The Appellate Litigation Group of the OGC, Professional Staff Group VII (PSG VII) distributes the court's orders and decisions to BVA, OGC (PSG II), and the Judicial Review staff of the C&P Service on a daily basis. The principals of those ac-

tivities regularly discuss the decisions and the impact that they will have on operations throughout VA. Discussions are conducted by phone and e-mail, on an as-needed basis, and there is a scheduled meeting the first Thursday of every month. That meeting includes the senior leaders of PSG VII, PSG II, BVA and the Judicial Review staff of the C&P Service. That group leads the effort to interpret the court's rulings, disseminate information, and monitor compliance with the court's rulings. BVA and C&P Service produce timely written assessments of the court's case law and disseminate them to decision makers in Washington and in VBA's 57 field stations. BVA, C&P Service, and OGC frequently participate in nationwide video broadcasts regarding the court's case law, and each of the activities participate in training sessions conducted around the country.

I agree that this process is likely to function most effectively and efficiently if one organization within VA were to lead the overall effort. I believe OGC is best positioned to assume this leadership role, and I have asked VA's General Counsel to develop a plan describing how he will manage this process.

Question 29. A VA contractor recently completed a report on the burial benefits administered by VA and found that funeral expenses had increased faster than the rate of inflation, and that the VA burial and plot allowances had not even kept pace with the rate of inflation. Do you have any plans to submit a request for legislation to increase the benefit rates?

Answer. H.R. 801, the Veterans' Opportunities Act of 2001, Title III—Memorial Affairs, Insurance, and Other Provisions, Section 301(a) would increase the burial and funeral expense allowances payable for service-connected deaths from $1,500 to $2,000, and for nonservice-connected deaths from $300 to $500. Section 301(b) would increase the plot allowance payable for veterans buried in state or private cemeteries from $150 to $300. Pursuant to section 301(c), these amounts would be indexed to increases in Social Security benefits under section 5312 of title 38. The initial increases in the various rates would be applicable to deaths occurring on or after the date of enactment of this legislation.

The adequacy of the current rates must be judged in the context of the overall package of burial benefits available to veterans, and with reference to other competing needs for finite budget dollars. The Government has responded to veterans' burial needs in recent years by establishing several new national cemeteries and by significantly enhancing the grant program under which state veterans cemeteries are established. The State Cemetery Grants Program now provides up to 100 percent of the costs of construction associated with the establishment, expansion, or improvement of state veterans cemeteries. This partnership between VA and the states helps to support the Department's strategic goal of providing veterans with reasonable access to burial in a veteran's cemetery. Since the 1998 enactment of Public Law 105–368, which in effect increased the permissible grant amount from 50 to 100 percent of construction costs, there has been an increased interest from the states in the program, as reflected in the increased number of pre-applications received.

Given the expanding availability of burial options within both national and state veterans cemeteries, and the competing demands for scarce VA resources, we can at this time support only that portion of section 301 that would increase to $2,000 the burial and funeral expense allowance for service-connected deaths. The last increase (from $1,000 to $1,500) occurred in 1988. The greatest obligation is owed to the families of those who have paid the ultimate price for their service, and we believe such an increase is warranted in their case.

Our preliminary cost estimate indicates that section 301 would result in benefit costs of $35 million in FY 2002 and a total benefit cost of $201 million for FYs 2002–2006. We estimate that an increase in only the service-connected burial allowance, from $1,500 to $2,000, would result in benefit costs of $5.3 million in FY 2002 and a 5-year benefit cost of $31.7 million.

VA is currently conducting a program evaluation and analyzing the contractor's report on burial benefits that was submitted to Congress in February 2001. Once VA's evaluation and analysis is complete, we can provide you with the results.

Question 30a. VBA specifically—and VA generally—has not had a history of stellar development and implementation of information technology systems. What strategies do you have for acquisition of new technology and ensuring VA-wide compatibility?

Answer. VA has adopted several strategies for acquiring current and emerging technologies, as well as ensuring compatibility across VA's Administrations and all of its diverse business lines. Foremost among these strategies is the integration of VA's IT capital investment process with the Department's capital investment program. This process requires VA's organizations to specifically address issues of interoperability when designing, developing, implementing, and maintaining IT sys-

tems. The VA capital investment process also evaluates an acquisition's ability to advance the idea of One VA customer service, requiring organizations to address issues regarding the compatibility and transfer of data.

As a complementary strategy to ensure compatibility in acquiring information technology, the Department is in the process of developing and implementing for the first time an enterprise-wide architecture that will bring together information on all of VA's business processes, information flows, applications, data, and systems infrastructure. It will serve as an integrated framework that, when tied to the capital investment process, will be an integrated framework of principles, guidelines, and rules for evolving and maintaining existing systems and acquiring new information technology. In addition, VA is including as part of its enterprise architecture, an updated Technology Reference and Standards Model that was developed several years ago and has been used as a guide in the acquisition of new technology since its adoption. When submitting an initiative into the capital investment review process, organizations are required to discuss conformance to VA's technical architecture to ensure compliance with VA standards. This adherence will cause compatibility issues to be sharply reduced.

To further ensure compatibility across VA, the Department uses its corporate IT contract, known as the Procurement of Computer Hardware and Software (PCHS) Contract, to encourage VA organizations to acquire computer products that conform to VA's Technology Reference and Standards Model. PCHS has been successful in implementing a common infrastructure across the Department.

In summary, VA is aggressively working to ensure that information technology is used in an integrated and compatible manner across the Department and that it supports VA's business operations in a One VA manner.

Question 30b. Do you think VBA is pursuing appropriate strategies? Has this determination been ratified by any outside entity?

Answer. VBA's experience in developing and implementing IT systems has not been without problems. However, we believe we are beginning to turn the corner toward success.

As a specific example, we can look at VETSNET. VETSNET has been under development far too long. Its development was delayed as new technologies and technical approaches came. and went. Over time, it has suffered from a lack of focus, the absence of clear goals and, at some points, inadequate management. These problems are behind us. The current VETSNET management plan addresses these problems. What began as too comprehensive an effort is now focused as a replacement system for the C&P claims processing system that was developed in the 1960s and 1970s. Still, concern remains about critical issues of performance and effective systems integration. Therefore, before we proceed to a fully operational status on VETSNET, we will conduct an independent audit of the overall system. If it passes all tests, we will go forward with its implementation on the current schedule. If not, we will develop a plan to extend the life of the current system and immediately begin the development of a replacement system.

VA is not spending any new funds on IT until we have defined an Enterprise Architecture that ends "stove-pipe" systems design, incompatible systems development, and the collection of data that do not yield useful information. We are convening a panel of world experts in the area of systems architecture to team with key business unit decision makers throughout VA to develop a comprehensive Integrated Enterprise Architecture Plan. It is VA's top management's highest priority, and in a matter of months, this new plan should be finalized.

All projects will be developed in an open architecture to facilitate eventual integration into a future system that will fit within the framework of the Enterprise Architecture previously discussed. All of VBA's IT strategies will be developed with this philosophy, as well as ensuring that systems will be part of an integrated, whole solution to the needs of our veterans.

Chairman SPECTER. Thank you very much, Mr. Principi.

We will now proceed with 5 minute rounds for the members. Starting with the Veterans Millennium Health Care and Benefits Act which provides access to nursing home care for veterans, we now have the largest aged veterans population in history, over 9 million veterans over age 65. In another decade, 42 percent of the entire veteran population will be 65 or older. What strategies is the VA adopting to increase long-term care, and does this budget proposal address this need?

Mr. PRINCIPI. Mr. Chairman, our nursing home census has gone down since 1998. We have dropped 9 percent, based upon the statistics I have before me, in the number of veterans who are occupying long-term beds. And, clearly, with the burgeoning elderly population, veterans over the age of 65 and, in some cases, quite a few over the age of 85, we need to do more. And, we are taking steps to do more, by building a model so that we clearly know how many beds we are operating on any given day in our system.

Chairman SPECTER. Mr. Principi, let's focus on the issue of resources. Does this budget enable you to apply adequate resources to this need?

Mr. PRINCIPI. Yes, I believe it does. One of our highest priorities is long-term care. So as we look at our budget and the allocation of those dollars within medical care, I will ensure that adequate dollars are provided to long-term care beds.

Chairman SPECTER. Would you give the committee a figure as to what you deem to be adequate for long-term care and an analysis as to how those funds can be provided from the existing budget. I am not asking you to make that rather complex computation at the moment, but I would like to go beyond the generalization and see what funding you anticipate for this line and where the money will come from.

Mr. PRINCIPI. Mr. Chairman, I can tell you that in our long-term care budget for 2002, we estimate we will spend in excess of $3 billion for long-term care. That is an increase over the fiscal year 2001 estimate of $2.8 billion. So, we are increasing our long-term care needs by approximately $200 million over the 2001 level.

Chairman SPECTER. How do you calculate the sufficiency of that increase compared to the need? And Mr. Garthwaite, do you want to supplement the Secretary's answer?

Dr. GARTHWAITE. We believe that there is considerable need beyond what we are able to meet. Based on the total amount of appropriations in 2002, we think we will meet the total need for 17 to 19 percent of long-term care needs of all veterans. We will meet 100 percent of the mandated needs.

Chairman SPECTER. Are you saying you will need more?

Dr. GARTHWAITE. I am saying we will meet 100 percent of the mandated need for the 70 percent and above, and we will meet about 17 percent—we currently believe we are about in the 15 or 16 percent range of all long-term care needs. So we will maintain and slightly gain on the market share for the nonmandated portion.

Chairman SPECTER. I do not understand that at all. Will the $3 billion be adequate to cover the needs for long-term care?

Dr. GARTHWAITE. Well, it will be adequate to cover the mandated needs for the 70-percent service-connected and above who are mandated to get long-term care from the VA. We will maintain our current effort and slightly increase it for the remainder of veterans.

Chairman SPECTER. Mr. Secretary, I would like a written response on the details as to how you evaluate the need for long-term care and how the allocated resources will meet that need.

[The information referred to follows:]

FY 2002 Increase: The FY 2002 increase of $200 million was developed in two parts. First, state nursing home (NH) increase was estimated on the basis of the

additional workload associated with activation of nursing homes funded through the Grants for Construction of State Extended Care facilities program. Second, VHA's networks, as part of their financial planning, estimated increases in other institutional and non-institutional programs. On the basis of (1) their estimated needs for LTC services in their geographical areas and (2) the overall FY 2002 budget request, networks provided estimates of resources that could be devoted to LTC. The total investment represents a 9.2 percent increase in resources and supports a census increase of 7,145 (1,879 increase in institutional care, and a 5,266 increase in non-institutional care).

Assessment of Long-Term Care Needs: VHA uses the LTC Planning Model to determine demand for LTC services. The model predicts demand for NH care and home and community based care (H&CBC) by priority group at a national, VISN, and local level. It is based on the 1996 Medical Expenditures Panel Survey for NH care and the 1998 National Home and Hospice Care Survey. The Federal Advisory Committee on Long Term care endorsed the use of this model. The model is sensitive to different utilization rates by age and disability level.

Future Projections: VA is in the process of validating data from the LTC Planning model within the Administration, along with other outyear budget estimates. Once completed, we will forward data projections to the Committee.

As with the demand for all health care by the VA, long term care demand, and an ability to provide this care, must be addressed. Policies for the type of long term care to be provided by priority group and its funding need to be clear. We will work with you on this issue over the next year.

Chairman SPECTER. Before my red light goes on, it is reported that you suggested in a briefing to staff that VA may have to limit enrollment at some point in the near future. What do you mean by limiting enrollment?

Mr. PRINCIPI. Since 1998, we have seen a dramatic increase in the number of Category VII's who have enrolled in VA's health care system. Category VII's are the lowest priority nonservice-connected, higher income veterans. That number has grown from approximately 350,000 to over 1 million who have enrolled in the system. Of that number, approximately 700,000 actually seek their care in the VA health care system.

If that trend in this Category VII continues at the same dramatic rate as the past few years, we may have to limit the enrollment of Category VII's. And, Category VII now comprises 20 percent of the care provided in VA health care facilities, about a third in some of the Networks. New York is an example of a Network where about a third of their workload is the Category VII's. Many of these Category VII's come to the VA in order to have their prescriptions filled. The VA has a very, very generous prescription program and we see a lot of the nonservice-connected, higher income veterans are coming into the system to avail themselves of that benefit.

So, clearly, as we look at the future of the VA, we need to consider balancing out the needs for our service-connected, lower income veterans, and balancing the needs of the Category VII's as well. But, it was strictly Category VII's.

Chairman SPECTER. The red light went on in the middle of your answer. So I will observe it and turn now to Senator Wellstone.

Senator WELLSTONE. Thank you, Mr. Chairman.

Mr. Secretary, I want to followup on the chairman's question. By the way, part of my context is the Independent Budget that a number of veterans organizations put together. A couple of years ago, veterans organizations were being told you are always criticizing and to be proactive, so they came up with their budget. I do not get the arithmetic of this. I want to be a harsh critic, not of you, of the budget, because, frankly, I have to believe that both you and

Mr. Garthwaite and others would like to have more resources to work with. I believe that.

If you just take medical inflation alone, my understanding is we are talking about $900 million, or there about. We are only talking about an additional $1 billion now. The CBO, going back to the Millennium Health Care Act, they estimate that the noninstitutional—and that is what we want to do, right, want the veterans to be able to live at home; I would argue we want all people to be able to live at home in as near normal circumstances as possible, with dignity—CBO says this will cost more than $400 million a year. The Independent Budget puts this at $500 million a year.

And I cannot tell you how important it is. I bet everyone of my colleagues has had the same experience, that when I am at the medical center in Minneapolis, you know it well, if I am visiting a veteran in a room, and say it is a World War II veteran and he has had a hip replacement, or maybe he is struggling with a disease, and if I get a minute with his wife and we go out in the lobby and sit down and talk to one another, maybe over a cup of coffee, she does not have a clue what she is going to do when he gets home. She is terrified. She loves him dearly, but she does not know how she is going to take care of him.

So, we are talking about $900 million just medical inflation. Another $400 million or $500 million more just for the Millennium. Then there is a commitment we have made to additional mental health care services which could run up to several hundred million as well. Then there is the spinal cord injury program that PVA talks about. They want to make sure that is adequately funded. Then there is the presumptive compensation of Vietnam veterans for diabetes and other diseases associated with Agent Orange, that's another $132 million according to the President's Blueprint. And then I would argue, and I want to ask you about this Heather French homeless veterans bill that we have introduced, that we ought to be putting services there. This does not add up.

Tell me how we can possibly give the veterans the health care that we are committed to giving them with this budget. The arithmetic does not add up, does it?

Mr. PRINCIPI. Again, I am not sure there is any Cabinet secretary who would not like to have a larger budget.

Senator WELLSTONE. Just say that.

Mr. PRINCIPI. Clearly, that is the case. We fought very, very hard. I am proud, and it is not a political issue, but this budget is 63 percent higher than the average percentage increases over the past 8 to 10 years. It is 14 percent higher in health care alone over the past 8 to 10 years—average percentage increase.

So, clearly, Mr. Wellstone, sure, there are lots of unfunded mandates that we have to comply with—important ones. The emergency care, to provide veterans with emergency care who cannot get to a VA hospital——

Senator WELLSTONE. That is another issue. Thank you, I forgot that one.

Mr. PRINCIPI. It is almost $500 million to private sector hospitals that will come out of the direct health care system.

So, yes, sir, with more dollars we can certainly do more in extended care, and we can do more across the board. What we have

to do when you give us a final number is to make sure that it is spent in accordance with the priorities and dictates of the committee, as well as our own. If it is a $1 billion increase, then we will apply it to the important issues of homelessness and extended care.

Senator WELLSTONE. I would like to thank you, my time is going to run out, thank you for adding that additional because the sort of scandal of this is we have got another 1 million veterans who do not have any coverage and we are going to try and cover them through emergency care.

My point is, look, this is not Democrat going after a Republican administration. I hated the flatline budgets. I was as openly critical of those flatline budgets as anybody in the Senate, and I understand what you are saying. But I just will tell you, and I followup on the chairman, I add up the arithmetic and I look at the needs and I look at the commitment, and this budget does not do it. We are going to have to do better.

Might I just ask you whether or not, not a yes or a no answer, but I am very focused on—Heather French has been a Miss America who has been a great advocate, I think her dad was a DAV member, for homeless veterans—this Homeless Veterans Assistance Act that I am introducing with Lane Evans and I hope many other colleagues, I want to get your quick reaction whether we are going in the right direction with this.

Mr. PRINCIPI. I think you are certainly going in the right direction. I spoke to the Homeless Coalition last week and I told them of my unswerving commitment to this issue. I want to see homelessness amongst the veteran population eradicated. I intend to walk the talk. I intend to establish a Secretary's advisory committee on homelessness issues. I believe that I have the commitment of Dr. Garthwaite and his people so we will be able to dedicate the resources and, we will work with you to do what is necessary. Such as the grant per diem program that has done so well, the multifamily housing program, which we just got approval to make loans so that we can start buying or building multifamily homes for veterans who are in transition, homeless veterans. These are the kinds of things we should do.

And we should also hold people accountable to make sure the dollars we are spending are working, that veterans are indeed getting jobs, that they are able to stay away from drugs and alcohol abuse. We need to put the money to the programs that are working and succeeding, and we need to have milestones and metrics by which we can determine what is working and what is not working.

Senator WELLSTONE. Thank you, Mr. Secretary.

Chairman SPECTER. Senator Campbell?

Senator CAMPBELL. Thank you, Mr. Chairman.

Mr. Secretary, I was interested in your comments. I think I can speak for all of us in saying we appreciate the increase in the budget. But I have to say that Senator Wellstone is right on. It is still not meeting the needs. The veterans are all in town now, as you probably know. The last few weeks the American Legion, the VFW, the Paralyzed Veterans, and so on, are all coming in and talking to us and they are all pretty much saying the same thing, that the budget is not keeping up with the needs.

I also was very appreciative that you are going to try and focus on increasing the speed of the claims process. That is one of the biggest complaints we get in our individual offices, people that have long waiting periods before they are taken care of.

But with the limited time, I want to focus just a question or two on the veterans' cemeteries. As I understand it, about 1,000 veterans are dying a day, World War II veterans, and we are simply running out of space. I am a veteran, by the way, and I have no intention of availing myself to that process in any near future. But I would still like to know the answer on how we address that. Let me ask you just a couple of specific questions.

Since we do have budgetary constraints, if someone, a nonprofit individual, has a piece of land and they want to donate it to the Veterans Administration for the expressed purpose of using it for a veterans' cemetery, can that be done, and how do they do that?

Mr. PRINCIPI. Yes, it can be done, and it is done. I believe the new cemetery that will be opened in Atlanta is the result of a grant by a family of 700 acres to us.

Senator CAMPBELL. Do you need legislative approval to accept it, or can you just accept it?

Mr. PRINCIPI. No, we can accept it once a determination is made, I believe, that we are going to expand a cemetery in that area. So, I think, we need to have an understanding that there is going to be a National Cemetery in a given location, at which time our people go out and look at the possibility of land being purchased or granted.

Mr. RAPP. I am Roger Rapp. I am the Acting Under Secretary for Memorial Affairs, the one involved with doing these new cemeteries. The cemetery that the Secretary referenced in Atlanta is the result of a donated property, donated to the Federal Government to do a National Cemetery, in a spot that we had identified to do a National Cemetery. The Secretary has statutory authority to accept donated land.

Senator CAMPBELL. Are those grants of land tax deductible?

Mr. RAPP. Yes, they are.

Senator CAMPBELL. Just one last comment, Mr. Chairman. I happened to speak to the Secretary just a little bit before we started and he tells me he is going to be visiting Fitzsimons in Colorado in the near future. Some years ago when we were dealing with the base closure acts—you know how tough those were to get through—when you talk about closing a base, every community in the area gets very worried about the loss of jobs, loss of access, and so on.

Fitzsimons has really been a model, and I think you are going to find that the local community, Aurora and Denver, is very, very happy with that transition. They have a terrific interaction with the University of Colorado and with the local community, and they have used that relationship to interest some pharmaceutical companies and all kinds of health care allied industries in moving into that area.

I do not know what other people are doing in other areas with those closed bases, but you might take a look at that as a model. They have generated just hundreds of millions of dollars of private sector money with the little amount that we put into the transfer.

Mr. PRINCIPI. Dr. Garthwaite and his team will look into the possibility of whether Fitzsimons can be converted into a VA-university hospital and some of the repair and modifications that would have to be made to Fitzsimons. So it is under review, sir. I do not know where it is going to lead, but we will keep in close touch with your office.

Senator CAMPBELL. Thank you. And one last little comment. I guess one of the very, very few complaints I have had about the VA is that when they decide to close a place, they have not in the past taken the locals into consideration very much. We have an old hospital called Fort Lyons, it is probably not cost-efficient to keep open, and it is being closed, as you know, in southeast Colorado. The biggest complaint down there was, of course, the anxiety of what happened after it closed. It is going to be turned over to the State of Colorado. But I would encourage you, when there are any changes that affect local communities, to have somebody go out there and do some town meetings or some old fashioned public hearings so the VA can hear from people about what is going to happen. That will help us because I will not get so many angry calls and letters, as you might guess.

Mr. PRINCIPI. Yes, sir, we will.

Senator CAMPBELL. Thank you, Mr. Chairman.

[The prepared statement of Senator Campbell follows:]

PREPARED STATEMENT OF HON. BEN NIGHTHORSE CAMPBELL, U.S. SENATOR FROM COLORADO

Thank you, Mr. Chairman. I would like to welcome you, Mr. Secretary, and thank you for appearing before the committee today. I am looking forward to your testimony which will give us a better picture of how the Administration is going to address the serious issues facing the VA as we begin a new century.

I am encouraged that President Bush has said his goal is to modernize our veterans' health care system and to speed up the agency's notoriously slow claims process. And, I see your appointment, Mr. Secretary, as a powerful sign that this administration wants to take better care of its veterans.

You have said that the nation can not ignore its debt to its military veterans. That attitude will go a long way in tackling the tough job ahead of you. I think we can all agree that one of our greatest national responsibilities is the welfare of our nation's veterans. It is critical that we find a balanced way to make good on the promises to them.

I have looked at the testimony of the many service organizations testifying at the joint hearings during the past month, and I have listened carefully to the Colorado veterans who have met with me.

Though I am encouraged with the overall FY 2002 funding increase, and particularly the increase for medical care, I continue to be concerned that we find a way to take care of what will be an increasing number of elderly veterans. They will need nursing homes and long term care facilities, they will need state of the art health facilities and services, and they will need new ways to access that care. Access to quality health care for women veterans is also an important issue.

And, I remain concerned for the present backlog that continues to hinder the adjudication process of veterans' claims appeals. I understand that is one of your top priorities, and I heartily support you in that objective.

I look forward to hearing more details of your budget plan and how you plan to address these issues in an efficient and effective manner within the proposed budget.

Speaking as a veteran, I want to do all we can to serve those who have so honorably served all of us.

I thank the chair and look forward to today's testimony.

Chairman SPECTER. Thank you, Senator Campbell.

Senator Miller?

Senator MILLER. Mr. Secretary, I applaud your appointment and I believe that you are going to be a great Secretary who is going to be able to look after our veterans and also be, at the same time, a steward of taxpayer dollars. And I think you can do both at the same time.

I know that you have spoken about there be a better coordination between the Veterans Administration and the Department of Defense. We know that this lack of communication has resulted sometimes in duplication of services, with some beneficiaries actually being enrolled in health care programs with both agencies. Do we have any idea of what could be saved by eliminating these duplications of service? Have you spoken to Secretary Rumsfeld?

Mr. PRINCIPI. I have, Senator. I have spoken to Secretary Rumsfeld on several occasions. We are planning a meeting in the very near future. My staff is in the process now of developing a strategy paper on how we will proceed with some form of interagency understanding addressing some of the cross-cutting issues of both departments. I know they are having their own share of challenges and problems with TriCare and the costs associated there.

When I was Chairman of the Congressional Commission on Servicemembers in Veterans Transition Assistance, we believed that by consolidating the procurement activities of DoD and VA in pharmaceuticals and supplies and equipment, that the savings in this alone would be enormous. And by adopting a national formulary and using universal product numbers, we could save I think it was close to $400 million a year. I believe the Department of Defense IG also found that there were savings in excess of what the Commission had found.

So I believe there are opportunities for efficiencies, greater effectiveness that can expand the reach of health care. It is troubling to me any time we leave money on the table that goes in someone else's pocketbook, so to speak, and that we cannot use the money to provide more care to more needy people, whether they are dependents of military personnel, retirees, or needy veterans.

I look forward to getting together with the Secretary. I think we have made great steps, great progress over the past several years, and I applaud my predecessors for the work they have done. But I think more can be done, and certainly we need to do that.

Senator MILLER. I hope you will keep us informed as you move along with that.

Mr. PRINCIPI. I will, sir.

Senator MILLER. Thank you, Mr. Chairman.

Chairman SPECTER. Thank you very much, Senator Miller.

Senator Hutchinson?

Senator HUTCHINSON. Thank you, Mr. Chairman, and thank you for calling the hearing today. It is very timely.

Mr. Secretary, I want to thank you. I think the last time we had you before this committee I raised a question about VA architects and a long-term facility in northwest Arkansas and you responded promptly and got me the answers I needed. I appreciate that very much and compliment you for that.

Help me to understand the numbers a little bit. The $23.4 billion is a 4.5-percent increase. That is a $1 billion increase. And then you said there was another $200 billion that would be retained——

Mr. PRINCIPI. $200 million.

Senator HUTCHINSON. $200 million, which puts us at $1.2 billion. That is what, a 5——

Mr. PRINCIPI. A 5.3-percent increase.

Senator HUTCHINSON. A 5.3-percent increase.

Dr. Garthwaite, what is medical inflation right now?

Dr. GARTHWAITE. I am not 100 percent sure. One figure that has been quoted is 4.36 percent. I would say that the average increase that employers expect to pay or the Federal Employee Health Benefits folks, like many of us in this room have to pay, is closer to 8 and 10 percent.

Senator HUTCHINSON. My understanding was that health care inflation is running quite a bit higher than the CPI and inflation in general. On the surface at least, it would appear we are going in the wrong direction on this, that the amount of increase does not really even meet the increased health care inflation rate.

Mr. PRINCIPI. You know, Senator, an interesting point, since 1994, Medicare costs have increased in the 30's, I want to say 33 or 36 percent. In that same period, the medical CPI has gone up about 26 percent. And in that same period of time, VA's average costs have declined per patient 2 percent. So, clearly, we are very efficient.

I fully agree with what Dr. Garthwaite said. The medical CPI is high and, you are right, employers are paying 8 or 10 percent and even more than that a year. And we feel those cost increases. But we provide a lot of care. When you look at what has happened in Medicare and the medical CPI, the VA has done very, very well in controlling cost, bringing cost down, and moving more to outpatient care. We can do a lot. And with more resources, we can keep people off of the Medicare rolls and the Government would be saving money. That is the point I would make.

Senator HUTCHINSON. I do not dispute that at all. I think VA has done an excellent job. To me, that is a concern, with that aging veteran population, more acute health care needs, and a very modest increase, how you meet those competing interests.

The National Cemetery budget increased 11 percent, and the Benefits Administration increased was it 13 percent?

Mr. PRINCIPI. Yes, sir.

Senator HUTCHINSON. OK. If you have a 13-percent increase in benefits and an 11-percent increase in the cemeteries, what is the percentage increase on the medical care side? It has to be less than the 5.3 percent.

Mr. PRINCIPI. It is 4.8 percent. Taking the $1.2 billion and rounding it to $1.2, it is actually a little above $1.2 billion, but when you divide it up that is what I come up with, about 4.5 or 4.8 percent in medical care, 13 percent in veterans benefits, 11 percent in cemeteries.

Senator HUTCHINSON. How are those priorities determined on the amount of increase in each area?

Mr. PRINCIPI. I think collectively. The senior leadership team works together and ultimately I have to make a decision. But it is done in consultation with the Under Secretaries, staff offices, and the comptroller.

Senator HUTCHINSON. Mr. Secretary, you mentioned that the Category VII's had gone from 350,000 to over 1 million and that 700,000 were seeking their care in the VA. So that is doubling the Category VII's, 350,000 to 700,000 who are using the VA. To what do you attribute that dramatic increase?

Mr. PRINCIPI. I think, clearly, veterans are seeing the attractiveness of the VA for a high-quality health care provider, in view of the fact that we have moved from a traditional hospital-based health care system to a more contemporary veterans-focused health care system with outpatient clinics within close proximity of their homes.

Senator HUTCHINSON. Let me stop you because I think you are right on and I am about to run out of time. The outpatient clinics, the whole goal of which was to increase access and to make health care closer to the veterans, is working. We are seeing that happen. But now you are talking about capping enrollment or stopping enrollment.

Mr. PRINCIPI. That is one option if it continues to grow. But, I think ideally we would like to see Category VII's continue to enroll in the system. We do have to do a better job of recovering some of the cost from the higher-income, nonservice-connected veteran. It was always, I believe, premised on Category VII's contributing more to the cost of the care.

Senator HUTCHINSON. I agree.

Mr. PRINCIPI. Today, we are collecting less than 15 cents on the dollar from these Category VII's for cost of care. I think we need to do better than that.

Senator HUTCHINSON. Let's work on that, higher-income veterans, we ought to be able to recoup more——

Mr. PRINCIPI. From insurance companies and——

Senator HUTCHINSON. Rather than keeping them from being in the system.

I know my time is up, but let me just followup one thing that was from the briefing you presented to congressional staffers last week, and I appreciate your doing that. But this chart indicates on the inventory of unprocessed claims a projection of going from 309,000 last year to over 600,000. That is not your fault, you are inheriting this. But that is very discouraging. What are your plans to get your arms around this problem?

Mr. PRINCIPI. Well, we have now lots of plans in the works. Certainly, the cornerstone is a task force comprised of the best minds of people who are in the VA who understand this area, the private sector management people, and CEO's of companies who can teach us some lessons they learned. Together they hopefully can come up with some practical, hands-on solutions on how to better manage, organize, and process claims.

We are also taking steps to hire more people. We are changing the way we do training. We are moving workload around to more productive stations, to resource centers. We are looking at technologies that we have implemented which have caused a logjam in productivity, and to maybe suspend some of that until we get out from under this mess.

The bottom line is I want to see the inventory at 250,000 claims, and processing times of 90 days in 2 years. We need to have mile-

stones to get to that point by March 2002–2003, to hold people accountable, to hold people's feet to the fire, and measure it every 6 months to see how well we are doing. So, we are going to implement new steps. We are gong to take some of the money you have given us to process claims, hire more people, train them differently than we have in the past, move workload around, and procure expert systems that will allow a rating specialist to do work more efficiently. Hopefully, the combination of these steps, and watching it, will allow us to get there.

Senator HUTCHINSON. Thank you, Mr. Secretary. Thank you, Mr. Chairman.

Chairman SPECTER. Thank you, Senator Hutchinson.

Senator Nelson?

Senator NELSON. Thank you, Mr. Chairman.

Congratulations, Mr. Secretary. This is the first time I have had occasion to see you since your confirmation. We appreciate very much what you are doing.

Mr. PRINCIPI. Thank you, Mr. Nelson.

Senator NELSON. During the President's Day recess, I had the occasion to tour the Grand Island, NE facility and found that a lot of improvements have been made there. There are others that are on the schedule for the future. I found it to be a facility very well-received by the public, but also a functioning facility. I appreciate very much what your Administration will do to continue to see that those improvements occur.

We may be victims of our own success in terms of utilization as we try to expand the availability of services. People take us at our word and they avail themselves of our services. So utilization increases will continue I am sure as we do that. Likewise, the medical care costs, inflationary costs, they are only one of the factors. Utilization will continue on its own even as you try to sort out the challenge of Category VII members.

What I am hopeful is that we will be able to put together a budget not just simply for veterans, but overall, for all the needs of our country and that we will be able to work together to do this on a bipartisan basis. Otherwise, I am very concerned that the veterans may be part of the process that is left out or not included at the level that we need them to be included.

Let me also comment that as I toured the facility in Nebraska, there were two things that came to mind. One is that the President put a statement in the budget that this special effort would be made to serve veterans who live in an underserved geographic area. Nebraska, like many other rural States, would be in that category. I am hopeful that we will be able to see that promised carried out in a meaningful way.

The final thing that I would like to say, and this is not just a statement but is, in fact, a question for you, one of the concerns about the means test is that in a rural area you can be land rich and cash poor. Is there any thought about excluding family farm land from the means test in establishing whether or not a veteran would qualify for care? I would hate to see veterans have to sell their family farm to realize the assets necessary so that they can pay for their care. It seems to me that there may be a way to look at the means test that takes into account assets that can be re-

duced to cash in some meaningful way versus those that cannot. And as a Senator from a rural State, I have a great deal of interest, I am sure others share that interest, too.

Mr. PRINCIPI. I am sure. It is a unique problem. I think it is a problem shared in some urban areas as well, where mom and pop have owned——

Senator NELSON. Right, the family business.

Mr. PRINCIPI. They have owned a business and live above the business, and they have the assets tied up in that grocery store or clothing store, but they are not wealthy in terms of how they qualify. We have talked about that, sir, and I think we need to continue to do so to make sure that it is fair, and that people can access the system, so that they are not unwittingly thrown into a Category VII group, but that they can gain access. I hope by working in a bipartisan manner we can get the resources we need so we can allow them to come into the system, irrespective of what category they are—Category VII's or Category I service-connected. We need to do that.

Senator NELSON. Thank you.

Chairman SPECTER. Thank you very much, Senator Nelson.

Senator Murray?

Senator MURRAY. Thank you very much, Mr. Chairman, for having this hearing. I apologize for being late.

Mr. Secretary, it is great seeing you again. I really want to welcome you to this committee and let you know how much I am looking forward to working with you. But I want you to know the veterans in my State are really delighted that you are doing this and give you their best as well.

I think you have one of the toughest and most important jobs in the cabinet because you represent a group of people who really do not often feel like they have a voice. They have served our country with honor and pride and they do not like asking. But they are today in a position of having to ask because their needs are not being met. I know that President Bush has promised a $1 billion increase in the VA budget. I am happy about that but I am also very concerned about whether a surplus will materialize and we will have the ability to put that increase in there.

I am curious as to whether you think that increase is sufficient to address the real needs that are out there for our veterans, particularly with the health care system. I would just love to hear your comments on what you think the needs are in our health care system and what we need to address that.

Mr. PRINCIPI. Thank you, Senator Murray, for your kind words. It is, indeed, the greatest job in the Cabinet and, I think a very difficult one, and I certainly accept that.

I am pleased with the budget. I need to tell you that the first couple of weeks after I arrived and saw what OMB passed back to me, I thought I would have the shortest tenure in history because I did not think I could survive, or would want to survive. But, we managed to get it up to a $1 billion increase. Certainly, as I mentioned to Senator Wellstone, I know I am not the only one in the budget who believes they need more money or would like more money, but I am grateful for what I consider a significant increase

relative to past years when—again, not a political issue—when we did not even get that high.

I believe it is a workable budget. I know it is only the first step in the process and the Congress has a say in this matter as well. But, I believe it is workable. We need to be careful on how we prioritize for long-term care and other special programs that the Congress has spoken about. We need to make a better effort of collecting medical care cost recovery. You have given us the authority, when I was here as a young staffer more than 10 years ago, to collect from insurance companies for the nonservice-connected care of veterans who have insurance. I do not think we have done a very good job in collecting that. You have told us we can keep that money in our medical centers and that it can be used to expand the reach of care. We have improved, but I think we have a long way to go.

And we have the CARES process underway now to take a look at our infrastructure to see how it should be realigned. We are not really in the real estate business, we are in the health care business. And if there is real estate that we have that can be used for other purposes, for assisted living or whatever it might be, that allow us to cut down our infrastructure cost, more efficiently utilize our infrastructure, I think we can further expand the reach of health care.

So I think there are things that we can do, and must do, to improve the delivery of health care. Opening all these outpatient clinics is a much more effective way to reach veterans and provide health care rather than having them drive to an inpatient facility maybe hundreds of miles away. And, we are doing that. We are transitioning the health care system. So I think it is a good start.

Senator MURRAY. I look forward to working with you, hearing your ideas, and working with our committee to make sure that we fund these really important needs. I urge you to really have good communications with veterans because change is not easy for people who have seen an awful lot of change and do not trust what the word "change" means anymore. I really would like to work with you on that.

In your testimony, you state that the VA will fully implement the VA's "duty to assist" role. As an author of that legislation, I want to know exactly what you mean by that.

Mr. PRINCIPI. I am sorry we had to get into the situation where we had to overturn the court and have legislation. The "duty to assist" legislation will require us to review approximately 342,000 claims for well-groundedness. But, we are allocating $134 million of this budget increase, 13 percent increase over last year, Senator, that will be used to bring on 800 additional employees into our Benefits Administration. A significant number will be used to allow us to work on "duty to assist" and the claims backlog. Coupled with other steps, procurement of expert systems, I believe we will, indeed, fully implement the legislation and get on with reducing the backlog.

Senator MURRAY. Great. I am delighted to hear that. Let me just also thank the Secretary for his work with one of my constituents. I really appreciate it and hope we can resolve it very quickly.

Mr. PRINCIPI. I hope so. I think we are well on our way to getting that resolved, Senator.

Senator MURRAY. Thank you. Thank you, Mr. Chairman.

Chairman SPECTER. Thank you, Senator Murray.

Secretary Principi, in looking at the overall budget, we do not have any specification yet as to the breakdown, we simply have the total figure. I note that the House Committee has recommended an increase of $2.4 billion as opposed to $1 billion, raising the same question which has been raised at this hearing, which is whether the administration's budget is adequate. I am skeptical that it is but I am going to reserve judgment until I see the fine print as to how you are going to make your allocations and also until we see how you may undertake some other measures within the VA to help on the funding side.

You had mentioned briefly the issue of insurance carriers paying. The estimate has been submitted that the VA is collecting less than 15 percent of the money spent on the care of the priority VII patients. Do you know if that is true?

Mr. PRINCIPI. Yes, that is true.

Chairman SPECTER. What can be done to collect on those insurance policies which might add substantially to the resources of the Veterans Administration?

Mr. PRINCIPI. Well, certainly, I think one of the first steps is to identify the veterans in Category VII, the nonservice-connected, who carry insurance and finding a way to obtain that data. That is the first thing.

Chairman SPECTER. Is there any problem with obtaining that data?

Mr. PRINCIPI. Well, I think we just have not done very well in learning whether veterans have insurance. Dr. Garthwaite is closer to it, maybe he can just talk about that for a moment.

Dr. GARTHWAITE. I think there are several aspects that are important. One is that veterans believe that if they use their insurance too much, they might lose it. So they do not always want to share the fact that they have insurance. And it is a voluntary process for them to give us that information.

Chairman SPECTER. Dr. Garthwaite, what do you mean it is voluntary? Does the VA ask the veteran if they have insurance?

Dr. GARTHWAITE. Right. We ask, but we do not have a good way to check to see if they have given us accurate information and told us about insurance policies that they might have.

Chairman SPECTER. Let's back up just a minute. Does the VA always ask?

Dr. GARTHWAITE. We do ask and means test any nonservice-connected veterans, yes.

Chairman SPECTER. In what way do you make the request, is it orally, is it in writing?

Dr. GARTHWAITE. They sign a form.

Chairman SPECTER. It is a serious matter to provide false information to the Federal Government. What I would like you to do, I may be wrong, but I note some hesitancy in the response about—well, let me put it this way, give us a written report as to how you make the request; is it oral, is it in your regulations, do you put it in writing, do you put on the writing the kind of language which

appears on the tax return about subject to the penalties if you do not provide an accurate answer. I think that kind of information is something VA is entitled to obtain. And you are talking about Category VII. I know that the Veterans Administration would not like to cut down on the priority VII people, but you have to establish your priorities. So, really, in asking them for their insurance, you are saying to them we need the resources in order to continue the coverage. But provide the committee in writing with precisely what is the way of seeking the information and what you could propose to do to sharpen it up.

Dr. GARTHWAITE. We would be happy to.

[The information referred to follows:]

Insurance Identification Process: Insurance identification has been problematic for the VA. Although insurance information is requested during the enrollment process and is recorded on the VAF 10–10EZ form, we believe that we miss a substantial number of individuals with some type of billable insurance coverage.

Questions concerning insurance information are contained on the VAF 10–10EZ. This information is also updated periodically throughout the year. A veteran can also provide updates at any time to reflect any changes in data. Medical centers obtain insurance information using several methods:

1. During the initial interview process: Intake personnel request the information during the enrollment registration process. Each veteran is queried for a health insurance card as well as any applicable spousal coverage. If the veteran has an insurance card, a copy of the card is made. If the veteran does not have an insurance card, they are asked to provide the name of the insurance company that provides their health insurance coverage. Veterans are also asked to provide their employment information, as well as spousal employment information. Insurance and employment information is verified and recorded into the VistA system.

2. Using the 'pre-registration' process: Pre-registration clerks use a call list to contact veterans two weeks prior to their scheduled outpatient appointment. The purpose of the pre-registration process is to update demographic data, including health insurance information prior to the outpatient visit. Insurance verification clerks use a similar process and contact veterans two weeks before an inpatient admission for updating demographic data, to include all health insurance data.

3. Mailing of Questionnaires: Medical centers can generate reports detailing information for patients with upcoming scheduled appointments where there is no listed health insurance. Staff then mail these patients a questionnaire to be completed and returned to the medical center. The questionnaire requests updated addresses, employer, next-of-kin, telephone number, and pertinent health insurance information.

Insurance Verification Process: Insurance verification is the process used by the insurance verification clerk to contact the veteran's insurance company to determine the policy benefits and exclusions for appropriate billing action. The insurance verification clerk uses the information in the VHA data system insurance buffer file for verification with the applicable insurance companies. Information that is verified includes the name of the policyholder, policy number, effective date of coverage, expiration date of coverage, type of coverage, special riders, applicable exclusions and addresses for claims submissions. The process also includes determining if the insurance policy covers inpatient, outpatient, mental health, substance abuse, dental, prosthetics, skilled nursing, and home health care services.

Pre-certification requirements for inpatient and outpatient care are obtained during the verification process. The pre-certification information is particularly important for inpatient care. Many insurance companies require pre-certification for outpatient services such as ambulatory surgery and psychiatric treatment. The insurance verification clerk also determines the percentage that the insurance will reimburse on submitted claims and obtains information about deductibles and out of pocket expenses, as well as lifetime maximum benefits coverage.

After verification of the information, it is entered into the patient insurance file and is readily available for all users. The overall benefit for insurance verification and re-verification is that it enables the VA to send accurate claims to the insurance companies, decreases the number of claims that need to be cancelled and submitted to different insurance companies.

Planned Actions: VHA recently initiated several pilots with private sector firms that indicate that they can assist in identifying billable data to improve insurance identification. VHA is also in the preliminary stages of discussing with the Health Care Financing Administration (HCFA) the development of a match with the Medicare common working file primary insurance data base that may help us identify billable insurance for veterans. Finally, VHA is in the process of revising VA Form 10–10EZ to include a certification that the information the veteran is providing is true and accurate. The form will also include a notification of penalties for false reporting.

Chairman SPECTER. In 1999, the Veterans Administration requested, and the Congress approved, legislation authorizing the VA to modify existing copayment rates for a variety of services. Despite the congressional action over a year ago, no such changes have been proposed. What do you have in mind on that, Mr. Secretary?

Mr. PRINCIPI. You are absolutely correct, sir. We have not done so. We are in the process. Dr. Garthwaite and I have talked about it as late as this morning that we need to get on with taking a look at the copayments to ensure that they are at the right level, that they do not discourage or deny veterans the opportunity to come to the VA for care, and that, at the same time, especially in the Category VII's again, your higher income veterans who have average incomes of about $40,000, pay a more realistic cost for their care.

I think pharmaceutical prescriptions is a good area, where we have been at $2 for a long time, and we all know that for a 30-day or a 90-day prescription for certain medications, many Americans, unfortunately, pay hundreds upon hundreds of dollars. We believe we should raise that a slight amount, to perhaps $7 for the more expensive medications, that would allow those dollars to be used to offset some of the cost of the rapid growth in pharmacy costs, and allow us to provide prescriptions for more veterans.

At the same time, we need to look at lowering the copayment for outpatient care. Right now we charge a veteran, nonservice-connected, $50 to come to a clinic for a simple examination. That is way too high. That should be more like $15. At the same time, if we do sophisticated outpatient surgery, whether it be a cataract surgery or something else, then there should be a higher copayment for that. So, we need to make our copayments much more realistic, which would provide us some income, some revenues for the system.

Chairman SPECTER. Mr. Secretary, what do you think is a reasonable period of time to give you to submit to the committee a report on this copay issue? 60 days?

Mr. PRINCIPI. No more than 60 days. Perhaps even as short as 30 days. We have been at it a long time. So we need to get on with it. We need to make some decisions and report to you.

Chairman SPECTER. No more than 60, perhaps as short as 30?

Mr. PRINCIPI. Yes.

Chairman SPECTER. Settle on 45? [Laughter.]

Mr. PRINCIPI. Deal.

Chairman SPECTER. In 45 days, Mr. Secretary, give the committee a report on the copay issue. You have already indicated your sensitivity to not discouraging veterans from seeking the service on an ability to pay. But it ought to be reevaluated. I believe if we are to hold down spending, in accordance with President Bush's re-

quest, and additional funding, that we ought to be looking very closely within the existing resources.

[The information referred to follows:]

Background: Public Law 106–117, The Veterans Millennium Health Care and Benefits Act authorized the Secretary, Department of Veterans Affairs, to set an applicable outpatient copayment rate, to increase the medication copayment amount, to establish maximum monthly and annual medication copayment amounts and to establish copayments for extended care services.

Current Status: VA is currently reviewing copayment-setting options for long-term care, medication, and outpatient treatment. Proposed regulations are being developed for each copayment category. Since these proposals are subject to the Notice and Comment Procedures of the Administrative Procedure Act, they are required to go through the normal regulatory process.

The normal process can take eight to ten months once we submit the proposed regulation to OMB. We intend to work closely with OMB to expedite this process. It is my intention that the long term care, revised outpatient, and revised medication copayment regulations be in effect in October, at the beginning of the fiscal year. General Counsel and the Office of Management will assist VHA in this effort. These regulations have been delayed long enough. This is a high priority for the VA to complete this work.

Chairman SPECTER. On Medicare subvention, Mr. Secretary, what do you think might be doable there?

Mr. PRINCIPI. Part of this discussion that we had earlier in response to Senator Miller's question about more cooperation with DoD in health care delivery, more coordination and partnership between the two systems. And I think the same holds true with HHS. I think Secretary Thompson should be involved in this discussion because of overlapping eligibilities.

On the whole issue of Medicare subvention, clearly, I would like to see us get reimbursed from Medicare for the cost of some of this care that we provide. HCFA has a different view of the whole thing. But I believe when we coordinate health care policy in this country, the VA needs to be part of that because we are such a large provider of health care. So I think Rumsfeld, Thompson, and Principi need to sit down with our leadership in health care and talk about some of these issues, and how we could provide it.

Chairman SPECTER. Mr. Secretary, I think your work with the Department of Defense is an excellent idea. Let me ask you to take the lead on the Medicare subvention idea, and give us a response, again within 45 days, as to what you see there. Because as we look at budgetary shortfalls, and again trying to honor the new President's request that we not add to his budget, those may be areas where we can come up with the funding and recognize the President's figure. But there is going to have to be some innovation and some ingenuity to work it out.

[The information referred to follows:]

As you know, much work and negotiation on this issue occurred in the last Administration. We have not had the time to review this proposal within the Administration. Just as before, much coordination and cooperation will be needed in the development of any proposal in this matter.

Chairman SPECTER. We have a vote in 14 minutes and we have five more witnesses.

Senator Murray, do you have anything you would like to add?

Senator MURRAY. Mr. Chairman, if I could just do a quick followup.

Mr. Secretary, you talked a minute ago about outpatient clinics, which I think are important in order to bring VA health care closer

to veterans. But I want to make sure we do not lose sight of specialty care needs, specifically, spinal cord injuries, which is important in my State. If you could just comment really quickly on your commitment to that.

Mr. PRINCIPI. We are certainly cognizant of the issue, the Millennium Care Act, that we maintain capacity at 1998 levels. I believe in all areas, with the exception of substance abuse, we have done well. We have increased funding. We are very, very close to meeting our capacity requirements in spinal cord injury, and we will continue to do so to make sure we maintain those levels.

Senator MURRAY. Good. Also, I am concerned about the staffing needs for specialty care, especially nursing shortages. If you could comment on that really quickly.

Mr. PRINCIPI. Well, I think it is a crisis that we need to deal with. That is another issue that is very, very important. I am certainly receiving reports from various sources that not only in specialty care, but around the system, there is a shortage of registered nurses. And we are losing some nurses to the private sector because the salary rates are going up because of the shortage. When you get to that intensive care, whether it be nursing home care or spinal cord injury, where the demands are even greater on the nurses, I think we have to be more innovative there. I know Dr. Garthwaite, we are looking at new equipment that allows us to transport spinal cord injury patients without the nurse having to do a lot of the lifting.

So we are trying to find new ways to bring nurses into the system; more attractive salary rates, better education, scholarship programs. But this is an issue that all American health care is going to have to grapple with.

Senator MURRAY. Absolutely. Thank you. And I would love to have you come out to the Seattle VA and see some of the work they are doing there with spinal cord injuries.

Mr. PRINCIPI. I would love to. And I am pleased that we were fortunate not to sustain damage at Seattle, Portland, or Vancouver, although, as you know, Senator, we did have some minor damage at American Lake. We have addressed that, we sent a team out there.

Senator MURRAY. He is talking about the earthquake, Mr. Chairman. Thank you.

Chairman SPECTER. Thank you, Senator Murray.

Thank you, Secretary Principi, Dr. Garthwaite, Mr. Thompson, Mr. Rapp, Mr. Catlett. We appreciate your being here.

I would like now to call Mr. James Fischl, Mr. Howie DeWolf, Mr. Rick Surratt, Mr. Harley Thomas, Mr. Dennis Cullinan. We very much appreciate the activity and the inputs of the veterans service organizations. In representing America's veterans, you have a very high degree of responsibility. As we so frequently find, we are squeezed on the scheduling with votes at 11. But we do appreciate your being here.

Let us start with you, Mr. James Fischl, Director of the Veterans Affairs and Rehabilitation Commission of the American Legion.

STATEMENT OF JAMES R. FISCHL, DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. FISCHL. Thank you, Mr. Chairman. Good morning, Mr. Chairman and members of the committee. The American Legion appreciates the opportunity to appear before you this morning. Our submitted statement outlines what we believe are VA's real funding needs for fiscal year 2002. Our budget recommendations are unchanged from those initially presented to this committee last September by Commander Ray Smith.

In the fiscal year 2002 outline for the Department of Veterans Affairs, the President calls for $1 billion increase for the entire VA. Simply put, the American Legion believes that this is not good enough. It is not good enough to continue to provide quality health care for eligible veterans. It is not good enough to offset fixed cost increases and medical inflation, and to address long-term care mandates contained in the Millennium Act. It is not good enough to support a strong medical and prosthetic research program. It is also not good enough to hire and train enough veteran service representatives to expedite the delivery of earned benefits for veterans and for their dependents.

The American Legion recommends a minimum $1.3 billion increase in health care appropriations for fiscal year 2002. Maintaining current health care services alone requires nearly a $900 million increase. The Veterans Health Administration has made significant progress over the past two fiscal years in correcting years of funding neglect and now is not the time to take a step backward from these recent gains.

The American Legion supports Medicare subvention and generating new revenue sources for Veterans Health Administration. We believe that the G.I. Bill of Health is a large part of the solution to VHA's annual budgetary dilemma. It is up to this Congress to provide VHA with the tools it needs to help improve its own financial situation.

In the past there has been much opposition to Medicare subvention. And as we heard this morning, part of the problem seems to be collection of benefits. We feel very strongly that collection of benefits is something that can, and should, be done. We look forward to the report that the VA will make on how they will collect money from third party sources. We believe that third party revenue is extremely important to the streamline of funds into the Department of Veterans Affairs.

The American Legion over the past few years supported a number of initiatives within VHA and VBA to improve the efficiency and effectiveness of service. The American Legion will continue to support reform that clearly enhances services to veterans.

Mr. Chairman, the American Legion notes for the record that the House Veterans' Affairs' Committee has called for a $2.1 billion increase in discretionary VA spending, stating that the Administration's recommended $1 billion, or 4.4 percent, increase outlined by Secretary Principi would just about keep veterans health care even. The American Legion urges this committee to act in the same bipartisan spirit as your colleagues in the House and to recommend an appropriate increase.

The American Legion looks forward to working with this committee to seek a long-term solution to VA's recurrent problems. We applaud your positive comments this morning that express the need for additional revenue. We look forward to working with you and joining with you in recommending an adequate increase in VA's discretionary budget for fiscal year 2002.

Mr. Chairman, that concludes my remarks, and I will be happy at some point to answer any questions the committee may have.

[The prepared statement of Mr. Fischl follows:]

PREPARED STATEMENT OF JAMES R. FISCHL, DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to appear before you today to express the views of The American Legion concerning the Fiscal Year (FY) 2002 Department of Veterans Affairs (VA) appropriations. Last September, The American Legion's National Commander Ray G. Smith offered many of these same recommendations during a joint session of the Veterans' Affairs Committees. The National Commander called for an overall increase in discretionary spending of approximately $1.75 billion in appropriations for VA in FY 2002. The purpose of the joint hearing was to paint a clear budgetary picture for the next administration and Congress. These recommendations were also provided to the major political parties, to all incumbents seeking re-election, and to those candidates who requested copies of the testimony.

The American Legion believes the formulation of the VA budget must be based on the needs of America's veterans, especially those with service-connected disabilities. This is especially important if the Department of Defense (DoD) plans to effectively resolve its recruitment and retention problems. America must honor those promises (implied or not) made previous generations of veterans. The American Legion believes taking proper care of those who have already served is the linchpin to future veterans. Veterans and their families are DoD's very best recruiters. Young men and women considering military service will seek out active-duty personnel, veterans and their family members for advice. Their voices will carry more weight in the decision process than slogans, recruitment materials or glowing promises.

Honorable military service must provide a veteran with more than individual pride, personal dignity and self-respect. Broken promises, hollow pledges and meaningless gestures do not strengthen national resolve, build morale, or promote unselfish devotion to duty. The thanks of a grateful Nation must be much more than holidays and parades. Long after the guns are silenced, the parades are over and the dead are buried, medals and citations do not help feed, house, educate or heal a veteran.

Mr. Chairman, The American Legion notes for the record that the House Veterans' Affairs Committee has called for a $2.1 billion dollar increase in discretionary VA spending, stating that the Administration's recommended billion-dollar, 4.4 percent increase outlined by Secretary Principi would "just about keep veterans health care even." The American Legion urges this Committee to act in the same bipartisan spirit as your colleagues in the House and to recommend an appropriate increase.

Over the years, Congress has implemented an array of programs designed to meet the needs of the veterans' community. Many veterans have never turned to VA for any assistance until now. Many of them never thought that VA would become an important part of their lives, but due to external factors (time, money and health), VA has become their life support system!

In addition to the specific budgetary recommendations outlined below, The American Legion believes Congress needs to focus on other budgetary solutions that involve both mandatory and discretionary funding. Medicare subvention is one such issue. Why must a Medicare-eligible veteran have to pay for treatment from VA for a nonservice-connected medical condition out of his or her own pocket, especially if he or she has purchased Part B? Congress allows VA to bill, collect, and retain third-party reimbursements, except Medicare. Why? Medicare-eligibility is not, and never has been, a priority or criteria for treatment in VA. When VA treats a Medicare-eligible veteran for a nonservice-connected condition, the veteran is billed. If these Medicare-eligible veterans want to seek health care in VA facilities, why can't they use their Medicare dollars to cover the cost of care for nonservice-connected medical conditions?

TRICARE is another such issue. All military retirees are eligible to seek treatment in VA medical facilities. Should they receive treatment for nonservice-connected conditions, the veteran or TRICARE will be billed. If the military retiree receives a prescription from VA, he or she can get the prescription filled at no charge in a DoD pharmacy. If the prescription is filled in the VA pharmacy, he or she may or may not have to pay a copayment (depending on the status of the veteran). This does not make sense, since the Federal government buys the medications for both agencies! This is but one instance where greater cooperation and coordination between VA and DoD could provide better quality, more timely and accessible health care coverage for all veterans and their families.

The American Legion greatly appreciates the actions of all Members of Congress regarding the increases in VA health care funding for FY 2000 and FY 2001 of approximately $3 billion. The American Legion believes such an increase was long overdue and has allowed VA to better meet the needs of veterans seeking care for their many medical problems. The American Legion believes VA should continue to receive full funding in to order to continue providing world-class health care. However, in order to do so, the Veterans Health Administration (VHA) requires just a billion dollars in new funding each year just to maintain existing services. With a mediocre budget request from a new Administration, the veterans' community must, once again, turn to Congress to make sure "no veteran is left behind."

The American Legion is very appreciative that Congress has realized that the flat-line funding imposed on VA health care under the Balanced Budget Act of 1997 was a bad idea. Just like the Medicare and Medicaid programs, the VA health care budget requires an annual increase to maintain its existing service level and to fund new mandates. For years, VA managers were asked to do more with less. The recent funding increases now allow VHA to do more with more, and will repair some of the problems related to long patient waiting times and limitations on access to care. Congress must not allow the recent funding gains to regress back to the day of doing more with less.

The past eight years have witnessed a significant reorganization and realignment of VHA resources and programs. Many dramatic and bold changes were initiated to improve VA's ability to meet the health care needs of the veterans' community. Now over four million veterans seek their health care in VA medical care facilities and even more veterans would come, if additional resources were available to cover the cost of care. VA continues to provide outstanding quality care that is recognized and praised by health care critics internationally. VA's medical research is still, dollar-for-dollar, the Nation's best investment. Quality, efficiency and effectiveness are the hallmarks of today's VHA.

Congress must continue to support increased VHA funding to maintain a world-class health care system. There are precious little additional efficiency savings expected throughout the system. Yet, those veterans now enrolled and using the system will continue to rely on VHA for the foreseeable future. Therefore, The American Legion believes that Congress must examine how to balance the annual appropriations process with additional funding that will not be offset by the Office of Management and Budget (OMB). The American Legion believes that a strategic goal of VHA should be to seek opportunities to increase funding sources, both appropriated and nonappropriated.

The overall guiding principle for VA must be improved service to veterans, their dependents, and survivors. This requires improving access to and the timeliness of veterans' health care, increasing quality in the benefit claims process, and enhancing access to national and state cemeteries. Specific American Legion objectives yet to be met by Congress include:

- Set the veterans' health care system on a sound financial footing for meaningful long-term strategic planning and program performance,
- Improve clinic appointment scheduling for access to medical treatment,
- Enact Medicare subvention legislation,
- Establish pilot programs to provide health care to certain dependents of eligible veterans,
- Improve cooperative arrangements between VA and DoD's TRICARE system,
- Reduce the benefits claims backlog and improve the quality of the claims process,
- Continued enhancement of the Montgomery GI Education Bill,
- Repeal of section 1103, title 38, U.S.C., removing the bar to concerning service-connection for tobacco-related illnesses,
- Increase the rate of beneficiary travel reimbursement, and
- All third-party reimbursements collected by VA should be used to supplement, rather than offset, the annual Federal discretionary appropriations.

The American Legion offers the following budgetary recommendations for FY 2002:

BUDGET PROPOSALS FOR SELECTED VA PROGRAMS

	FY 2001 Appropriations	The American Legion's Proposal
Medical Care	$20.2 billion	$21.6 billion
Medical and Prosthetic Research	350 million	375 million
Construction:		
Major	66 million	250 million
Minor	166 million	175 million
Grants for State Extended Care Facilities	100 million	80 million
National Cemetery Administration	109 million	115 million
State Cemetery Grants Program	25 million	25 million
VBA's General Operating Expenses	1.08 billion	1.2 billion

MEDICARE SUBVENTION

Public Law 105–33, the Balanced Budget Act of 1997, established VA's Medical Care Collection Fund (MCCF) and requires that amounts collected or recovered after June 30, 1997, be deposited in this account. Beginning October 1, 1997, amounts collected in the fund are available only for furnishing VA medical care and services during any fiscal year; and for VA expenses for identifying, billing, auditing, and collecting of amounts owed the Federal government fore such care. Public Law 105–33 also extended to September 30, 2002, the following Omnibus Budget Reconciliation Act (OBRA) provisions:

- Authority to recover co-payments for outpatient medications, nursing home and hospital care;
- Authority for certain income verification; and
- Authority to recover third-party insurance payments from service-connected veterans for nonservice-connected conditions.

The Health Service Improvement Fund was established to serve as a depository for amounts received or collected under the following areas as authorized by title 38, U.S.C., Section 1729B:

- Reimbursements from DoD for TRICARE-eligible military retirees;
- Enhanced-use lease proceeds; and
- Receipts attributable to increases in medication co-payments.

The Extended Care Revolving Fund was also established to receive per diems and co-pays from certain patients receiving extended care services authorized in title 38, U.S.C., Section 1710B. Amounts deposited in the fund are used to provide extended care services.

Congress is providing VA with the authority to bill, collect, retain, and use revenues from sources other than Federal appropriations. However, the country's largest health care insurer (Medicare) is exempt from billing; yet, its beneficiaries are welcomed and encouraged to receive treatment in VA medical facilities.

Currently, approximately 10.1 million veterans are Medicare-eligible solely based on their age. Criteria for Medicare-eligibility are different than eligibility for treatment in VA. In the VA health care network, certain veterans are eligible for treatment at no cost for medical conditions determined to be service-connected. Medicare-eligibility is not a priority or criteria for health care at no cost in the VA health care system. Other veterans are eligible for treatment at no cost, because they are economically indigent. All other veterans must pay for treatment received.

Medicare subvention would allow VA to seek reimbursement from the Health Care Financing Administration (HCFA) for treatment of nonservice-connected medical conditions of Medicare-eligible veterans. VA and HCFA should explore either the Fee-For-Service or Medicare+Choice options or both. Medicare-eligible veterans should not forfeit their Medicare health care dollars because they prefer VA health care to health care offered in the private sector.

More than 734,000 Medicare beneficiaries have lost HMO coverage over the past two years and another 934,000 seniors will be dropped by their HMO plans next year. Many VA-eligible beneficiaries are included in those dropped from coverage and will eventually come to VA for care. The argument that VHA is already reimbursed for its Medicare population and that Medicare subvention will result in double funding is mistaken. VHA is now mandated to provide care to all seven priority groups. As more Medicare-eligible veterans seek first time care in VHA, health care costs and subsequent waiting times will increase. It is imperative that Congress examine this issue and take the actions necessary to ensure that VHA receives all

funding necessary to execute its health care mission with quality and in a timely manner.

Medicare subvention for VA must be included in any planned Medicare reform legislation passed in the 107th Congress. Access to VA health care is an earned benefit. No Medicare-eligible veteran, treated for a nonservice-connected medical condition, should be deprived of his or her Federal health care insurance dollars to pay for the care received in a VA medical facility.

VETERANS HEALTH ADMINISTRATION (VHA)

The American Legion commends VHA for the evolutionary changes made over the past several years. Most, if not all, of these alterations were long overdue and necessary. This includes eligibility reform, enrollment, the reorganization of the 172 medical centers into 22 integrated service networks, the elimination of certain fiscal inefficiencies, and the expansion of community-based outpatient clinics. For many years, VHA's annual budget appropriation was the guiding principle behind its management decisions. To a degree this is still true. However, today there is growing evidence that VHA strategic planning will help guide future budget development.

The primary short-term objectives of VHA must be to improve patient access and health services delivery. The American Legion's VA Local User Evaluation (VALUE) guidebook cites patient access as the largest single source of continuing veteran complaints. In accordance with its strategic planning, VA annual inpatient admissions have decreased by 32 percent since 1994; ambulatory care visits have increased 35 percent. However, in some areas, like substance abuse, the number of veterans actually being able to access treatment has declined. This phenomenon, along with a large decrease in administrative and clinical staff, and a significant increase in patient enrollments over the past few years, has placed a huge strain on VHA's ability to meet its workload in a timely and consistent manner. As VHA becomes more proficient in attracting new patients, it must also provide consistent access to care across all 22 Veterans Integrated Service Networks (VISNs).

Currently, the national average waiting time for a routine, next-available appointment for Primary Care/Medicine is 64 days (with a range of 36–80 days). The next available appointments for specialty care:

Specialty Care	Average Days	Range
Eye Care (Ophthalmology & Optometry)	94	42–141
Audiology	50	22–91
Cardiology	53	19–78
Orthopedics	47	12–69
Urology	79	39–108

There are additional concerns about the average clinic appointment waiting times for dermatology and pulmonary clinics. However, these specialty clinics are not included in the VISN director's performance standards. Therefore, no national average waiting times were reported. These waiting times indicate that there are serious access differences between VA health care and private sector health care.

There are also reported concerns about long distances that veterans in rural areas have to travel for certain care. For example, veterans in eastern Montana must travel nearly 700 miles to Fort Harrison, MT for routine inpatient surgery. For complex surgical procedures, these same veterans are required to travel to Salt Lake City or Denver. This excessive travel places great strain on veterans and their families. Since 1994, the Miles City, MT VA Medical Center has reduced its payroll over $7 million per year by eliminating nearly 145 full time employee positions. The American Legion questions why contract services for required surgery have not been acquired to reduce excessive travel requirements?

In some cases, The American Legion believes VHA has gone too far, too fast in attempting to improve its fiscal efficiency. Veterans should not have to increase their travel time for the benefit of VA. Rather, VHA needs to improve its cooperation with other federal, state and private health care providers to improve the quality and timeliness of care for veterans.

VHA's short-term and long-term future must be clearly defined to be responsive to the needs of the veterans' community. All individuals who enter military service should be assured that there is a health care system dedicated to serving their needs upon leaving the military. That concept is especially important to disabled veterans and military retirees. The GI Bill of Health would ensure that all honorably discharged veterans would be eligible for VA health care on a permanent basis, as they would fall into one of the core entitlement categories. A unique feature of the GI Bill of Health is that it would also permit certain dependents of veterans

to enroll in the VA health care system. The American Legion advocates that dependents of veterans be allowed to use the system and that VA retain any third-party reimbursements for treatment. An additional significant step will be to enact VA-Medicare subvention.

At the current workload level, VHA requires an annual appropriation increase of approximately $1 billion to maintain current services and meet its prosthetics and pharmacy costs. The amount of potential efficiency savings is decreasing yearly. The projected $3 billion funding increase over FY 2000–2001 must compensate for the flat line budgets of FY 1997–99, and fully fund the provisions of the Millennium Act involving emergency and long-term care, Hepatitis C treatment. Consequently, there is a continuing need to adequately fund VHA's uncontrollable cost increases at an acceptable level in order to maintain capacity in the Special Emphasis Programs (Mental Health, SCI, Blind Rehab, etc).

Change within VHA, over the past several years, has been the result of a series of small steps. The American Legion acknowledges that the progress made within VHA has been extraordinary. However, this progress has to be sustained and reinforced. In order to accomplish this goal, Congress must unlock the creative potential of VHA to develop alternative revenue sources to complement the annual appropriations process, but these additional sources of revenue should not be used to offset the appropriated dollars from Congress.

At a recent VA planning meeting, VHA unveiled six strategic goals to be accomplished by 2006:

- Put quality first,
- Provide easy access to medical knowledge, expertise and care,
- Enhance, preserve and restore patient function,
- Exceed customers' expectations,
- Maximize resource use to benefit veterans, and
- Build healthy communities.

The American Legion believes these are important goals. However, we believe VHA must explore all opportunities to develop alternative revenue sources to complement its annual appropriations. To do less will continue to force VHA to solely rely on the annual budget process to establish patient treatment priorities. There is a distinct possibility that if future funding does not keep pace with the growing needs of veterans who seek treatment through VHA; the current open access to all seven-priority groups will close.

The American Legion recommends $21.6 billion in VHA.

TRICARE

The most significant recent change in military health care is the introduction of TRICARE (DoD's regional managed care program). TRICARE is facing many challenges to providing and maintaining a quality health care delivery system for active duty military personnel, military retirees, and dependents.

DoD continues to confront severe administrative problems with TRICARE. The American Legion is extremely concerned how DOD will fix these problems and if DoD can guarantee TRICARE's long-term success.

There are multiple reasons why TRICARE is failing to meet the expectations of its beneficiaries:

- Infrastructure and financial problems,
- Problems with provider networks—resulting in weak network links to subcontractors,
- The inability to attract and retain qualified health care contractors,
- No financial tracking system outside of the military treatment facilities,
- Difficulties in processing claims in a timely manner,
- TRICARE lacks portability between all 12 regions, and
- Military retirees and their dependents are required to pay an annual enrollment fee.

The American Legion believes that VHA can greatly assist DoD through expanded authority to provide care to TRICARE beneficiaries. With limited budgets, both VA and DoD must discover innovative ways to provide care to active duty personnel, to all veterans and military retirees, and to eligible dependents.

Congress recognized the utility of having VHA play a greater role in the treatment of TRICARE beneficiaries when it passed the Veterans' Millennium Health Care and Benefits Act (PL 106–117). This legislation requires VA and DoD to enter into an agreement to reimburse VA for the cost of care provided to retired servicemembers who are eligible for TRICARE and who are enrolled as Priority 7 veterans. These veterans would not be required to pay VA inpatient and outpatient

copayments. The program is to be phased in as DoD enters into TRICARE contracts after November 30, 1999.

Five years ago, it was impractical to suggest that VHA was capable of assisting DoD in resolving many of its patient treatment problems. Today, although not without concerns of its own, VA is in a much better position, both financially and organizationally, to assist with the delivery of health care to DoD beneficiaries. The American Legion believes that VA and DoD should better coordinate medical care and services to the extent possible, thereby eliminating duplication of effort and achieving greater cost efficiencies. With proactive planning, VHA can become the largest single provider of health care to America's veterans, military retirees and their dependents. DoD could then assume the responsibility of providing health care to active duty servicemembers, Reserve Component members and their dependents.

MEDICAL AND PROSTHETIC RESEARCH

The contributions of VA medical research include many landmark advances, such as the successful treatment for tuberculosis, the first successful liver and kidney transplants, the concept that led to development of the CAT scan, drugs for treatment of mental illness, and development of the cardiac pacemaker. The VA biomedical researchers of today continue this tradition of accomplishment. Among the latest notable advances are identification of genes linked to Alzheimer's disease and schizophrenia, new treatment targets and strategies for substance abuse and chronic pain, and potential genetic therapy for heart disease. Many more important potentially groundbreaking research initiatives are underway in spinal cord injury, aging research, brain tumor treatment, diabetes and insulin research, and heart disease, among others.

VA devotes 75 percent of its research funding to direct clinical investigations and 25 percent to bioscience. Patient-centered research comprises one of every two dollars spent on research within VA. In FY 2001, VA's appropriations funding for research is $350 million.

Gulf War Veterans' Illnesses

The American Legion continues to actively support Gulf War veterans and their families, as it has since August 1990. The American Legion created two programs specifically for Gulf War veterans, the Family Support Network in October 1990, and the Persian Gulf Task Force in October 1995. Today, The American Legion serves Gulf War veterans and their families at the community, state, and national levels through 15,000 local posts and an array of programs and services.

Thousands of Gulf War veterans, who suffer undiagnosed illnesses with a range of symptoms, know as "Gulf War veterans' illnesses," are not receiving adequate care or compensation from VA and DoD. As the number of sick Gulf War veterans has continued to increase, it is apparent that VA has narrowly interpreted and implemented the Persian Gulf War Veterans' Benefits Act (Public Law 103–446), effectively denying compensation to some of the veterans the law was designed to help. It is clear that the intent of Congress was not only to compensate Gulf War veterans with conditions that can not be diagnosed, but to also compensate sick veterans diagnosed with poorly defined conditions such as chronic fatigue syndrome and fibromyalgia. As a result of VA's narrow interpretation of PL 103–446, it has become quite clear that legislation is needed to amend Title 38 USC § 1117, Compensation for Disabilities Occurring in Persian Gulf War Veterans.

The American Legion makes the following recommendations in addition to the legislative course of action discussed above:

- VA and DoD should conduct their respective exams in a standard and uniform way as well as create a database that will merge the individual data from both exams so that patterns in health can be better analyzed,
- VA and DoD should aggressively move to educate its medical doctors about newly defined illnesses (Chronic Fatigue Syndrome, fibromyalgia, etc.) that are commonly misdiagnosed as psychological conditions. VA should also discourage its doctors from giving diagnoses for common symptoms unless diagnosed properly, so that the VA's Persian Gulf War Registry and DoD's Comprehensive Clinical Evaluation Program (CCEP) data will be accurate,
- VA and DoD should conduct extensive follow-up to Gulf War veterans who participate in the Registry and CCEP examinations to monitor health status.

Additionally, this past September the Institute of Medicine (IOM) released a much-anticipated report on the health effects of exposures during the Gulf War. Unfortunately, due to the lack of evidence and quality research on the long-term health effects of the various exposures these veterans faced during the Gulf War, IOM was unable to make any determinations regarding veterans' health due to exposures. IOM recommended additional research for long-term health effects. In light of the

inconclusive findings and IOM's call for additional research, appropriate action should be taken to extend the presumptive period for VA undiagnosed illness compensation claims which is set to expire January 1, 2002.

Additional research on the long-term health effects of the various hazards veterans were potentially exposed to during the Gulf War, as called for by IOM, will require additional funding. Anticipated extension of priority health care for sick Gulf War veterans will also require additional funding. The American Legion urges Congress to continue aggressive oversight of the implementation of the landmark Gulf War legislation passed by the 105th Congress (PL 105–368).

The American Legion recommends that Medical and Prosthetics Research be increased to $375 million.

MEDICAL CONSTRUCTION AND INFRASTRUCTURE SUPPORT

Major Construction

The VA major construction program is not being funded in an adequate manner. The major construction appropriation over the past few years has allowed for only one or two projects per year. Meanwhile, the number of priority projects continues to accumulate. For FY 2001, 16 major ambulatory care or seismic correction projects were submitted to Office of Management and Budget. Of this number, only one major VHA project is recommended. For FY 2002, 28 major projects are to be submitted for funding. The American Legion does not believe that the FY 2001 funding level of $66 million is sufficient to meet this goal.

The American Legion recommends $250 million for Major Construction.

Minor Construction

Annually, VHA must meet the infrastructure requirements of a system with approximately 4,700 buildings, 600,000 admissions and over 35 million outpatient visits. To do so requires a substantial inventory investment. The FY 2001 appropriation of $166 million for minor construction needs additional funding to meet future physical improvement needs. It is penny-wise and pound-foolish to reduce this investment. VHA was forced to delay approximately one-third of its priority minor projects. The American Legion believes that Congress must be consistent from year to year in the amount invested in VHA's infrastructure.

The American Legion recommends $175 million for minor construction.

GRANTS FOR THE CONSTRUCTION OF STATE EXTENDED CARE FACILITIES

Currently, this nation is faced with the largest aging veterans' population in its history. VA estimated the number of veterans 65 years of age or older will peak at 9.3 million in the year 2000. By 2010, 42 percent of the entire veteran population, an estimated 8.5 million veterans, will be 65 or older, with half that number above 85 years of age. By 2030, most Vietnam Era veterans will be 80 years of age or older. The State Veterans' Home Program must therefore continue, and even expand its role as an extremely vital asset to VA. Additionally, state homes are in a unique position to help meet the long-term care requirements of the Veterans' Millennium Health Care and Benefits Act.

State veterans' homes provide over 24,000 beds with a 90 percent occupancy rate that will generate more than seven million days of patient care each year. The authorized bed capacity of these homes is 90 nursing care units in 40 states (17,844 beds); 46 domiciliaries in 32 states (5,841 beds); and 5 hospitals in 4 states (469 beds). For FY 2000, VA spent approximately $255 per day to care for each of their long term nursing care residents, while paying private-sector contract nursing homes an average per diem of $149 per contract veteran. The national average daily cost of caring for a state veterans' home nursing care resident during FY 2000 was $137. VA reimbursed state veterans' homes a per diem of only $40 per nursing care resident.

On the basis of the available funding in FY 2001, a total of 42 priority one state home construction grant projects with an estimated cost of $110 million remain unfunded. As many VA facilities reduce long-term care beds and VA has no plans to construct new nursing homes, state veterans' homes are relied upon to absorb a greater share of the needs of an aging veteran population. If VA intends to provide care and treatment to greater numbers of aging veterans, it is essential to develop a proactive and aggressive long-term care plan. VA should work with the National Association of State Veterans' Home Directors to convert some of its underutilized facilities on large multi-building campuses to increase the number of available long-term care beds.

The American Legion recommends $80 million for the State Veterans' Home Extended Care Construction Grants Program.

NATIONAL CEMETERY ADMINISTRATION (NCA)

Currently, NCA oversees 119 national cemeteries in 39 states and Puerto Rico. The Department of the Army or the Department of the Interior administers sixteen other national cemeteries. Sadly, there are 57 national cemeteries closed to first interments. Recently, new national cemeteries were opened in Chicago, IL; Albany, NY; Cleveland, OH; and Dallas, TX. Major construction projects are planned at other existing sites to extend the active life of the cemeteries for as long as possible.

The National Cemetery Administration has no national cemeteries in some critically needed areas. Among these are Atlanta, GA; south Florida; Pittsburgh, PA; Sacramento, CA; Detroit, MI; and Oklahoma City, OK. Additionally, some existing cemeteries will soon run out of available space without significant expansion.

The National Cemetery Administration statistics project over 80,000 burials during FY 2001. The number of veterans' deaths is projected to peak at 620,000 in 2008 and slowly return to the 1995 level of 500,000 by 2020. Notwithstanding the development of six new national cemeteries over the past 10 years, there is an urgent requirement to continue the recent expansion. Without a strong commitment from Congress to take on this effort, VA will not be able to improve access to burial in national cemeteries for millions of veterans and their eligible dependents.

The American Legion believes that Congress should remove the current restriction on eligibility to an appropriate government furnished marker for veterans that have a marked grave. This outmoded statute affects over 20,000 families per year. This restriction should be removed so NCA can be of assistance to all families that seek appropriate recognition of a veteran's honorable military service.

The American Legion recommends $115 million for NCA. Additionally, Congress should commit to building six new national cemeteries by 2008 and provide appropriate funding in VA's major construction program for this purpose.

GRANTS FOR THE CONSTRUCTION OF STATE VETERANS' CEMETERIES

The State Cemetery Grants Program is an excellent complement to NCA. The enactment of PL 105–368 in November 1998 significantly improves the state grants program, but does not ensure that the states will commit to developing veterans' cemeteries in the areas of greatest need. Therefore, to strengthen the program, Congress must increase the burial plot allowance paid to the states and make the allowance applicable to all veterans. Additionally, to lessen the demand to invest millions of dollars in the construction and long-term maintenance of new national cemeteries, a significant increase in state grants applications funding must be provided.

The American Legion recommends $25 million in new State Veterans' Cemetery Grants.

VETERANS BENEFITS ADMINISTRATION

Mandatory spending for the payment of compensation, pension, and burial benefits by the Veterans Benefits Administration (VBA) for FY 2002 is expected to exceed $23 billion. This reflects the impact of recent new regulatory and legislative entitlements as well as higher average benefit payments, certain new proposed legislation, and a cost-of-living adjustment.

The proposed increase in discretionary funding for FY 2002 will do little, if anything, to improve VBA's claims adjudication process. The promised improvements in service cannot be achieved without a substantial staffing in the regional offices. This is clearly evident in the fact that the current backlog of pending claims, new appeals, and remanded cases from the Board of Veterans Appeals is continuing to grow rather than decrease. In addition, there will be a substantial increase in the regional offices' workload associated with new claims for diseases such as diabetes related to Agent Orange exposure, Hepatitis C, and radiation-related claims, as well as the readjudication of claims as a result of the Veterans' Claims Assistance Act of 2000. Additional funding is also needed to enable VBA to continue its efforts to reengineer their business processes, improve training, continue succession planning, and improve the overall quality and timeliness of the service provided to veterans and their families.

The American Legion is supportive of the broad performance and service improvement goals set forth in VBA's strategic management plan. Progress has been made in a number of areas under the current year budget. However, this is a long-term process and many significant challenges remain. Without adequate funding support at this critical period, VBA's implementation of a broad spectrum of operational, programmatic, technological, and administrative initiatives now underway or planned will be delayed and service will deteriorate. Disabled veterans must now wait months and sometimes years for their benefit claims to be decided. They are

deeply frustrated and disappointed by a bureaucratic system that appears to be "not very user friendly", inefficient, and frequently unresponsive to their personal problems and needs. VBA's budget for FY 2002 must ensure that progress toward its stated service improvement goals will continue and that veterans and their survivors receive the benefits and services they are entitled to in a timely manner

BENEFIT PROGRAMS

In FY 2002, the estimated number of compensation, pension, education, and burial claims is expected to increase over the FY 2001 workload projections. While the number of pension claims will decline, due to the high mortality among World War II veterans, this will be substantially offset by the expected influx of claims for diabetes, Hepatitis C, additional radiation-related diseases, and requests for readjudication under the Veterans' Claims Assistance Act of 2000. It is apparent from the growing backlog of pending claims and appeals, which is now in excess of 500,000 cases, that present staffing levels are inadequate to meet the current workload and provide veterans and other claimants the level and quality of service they are entitled to and deserve.

One of the biggest challenges facing VBA over the next several years, in addition to the much needed modernization of its computer systems, is the prospect of the large scale turnover among its most experienced and senior personnel within the next three to five years. This issue was recognized as a major concern in the FY 1999 budget request and we were pleased that additional staff for VBA has been authorized in each of the past three-year budgets. However, currently, only 45 percent of authorized decisionmakers have three years or more of experience. The prevailing level of inexperience, the sheer number of claims and appeals to be processed, and the legal and medical complexities of all types of claims has contributed to an unacceptable error rate and a growing backlog of pending cases. VBA is continuing its efforts to recruit new personnel, improve the level, and the availability of training. It has also instituted several initiatives that will not only help identify errors in adjudication and improve the quality of decisions, but will make individuals and managers personally accountable for the quality of their work. It is essential that these initiatives continue and be fully funded.

Hepatitis C Claims

Hepatitis C has become a national public health challenge and The American Legion is deeply concerned by the prevalence of the Hepatitis C virus in the veteran population. According to government estimates, there are approximately 4 million Americans with this virus and many have serious health problems, such as cirrhosis of the liver and liver cancer. According to VA estimates, 400,000 veterans may be infected with this disease. The reason why veterans are more likely to have Hepatitis C than the non-veteran population is because of the presence of a variety of risk factors inherent in military life and the increased risk of exposure by those serving on active duty.

The American Legion has been generally pleased by VA's responsiveness to the Hepatitis C problem. In light of study data showing an increased incidence of this disease among the veteran population, The American Legion asked the VA Secretary to consider issuing regulations providing for presumptive service connection. Proposed regulations are now under development and will, hopefully, be available for public comment later this year. When finalized, these are expected to result in a substantial influx of claims for disability compensation and VA medical care. While these regulations will assist veterans in establishing entitlement to disability and medical care benefits, we believe that Congress should codify by statute the presumptions which will apply to Hepatitis C claims. This will ensure VA has the necessary resources to fully and fairly adjudicate this type of claim and provide the support needed for its outreach, information, and treatment programs.

The American Legion recommends $1.2 billion in VBA–GOE.

BOARD OF VETERANS APPEALS

The American Legion believes the Board of Veterans Appeals (BVA) will require additional staffing resources for FY 2002, so that efforts to improve productivity and reduce their response time can continue. Staffing at the BVA is currently 520 FTEE. However, due to a number of internal and external factors, the BVA's workload is expected to remain high and their response time increase to over 220 days. In FY 2002, BVA expects to increase production slightly and reduce the number of pending appeals at the Board. However, these modest gains will be largely offset by the impact of directives of the Court of Appeals for Veterans Claims that require additional time, effort and resources in deciding appeals and those cases remanded from

the Court to the Board for readjudication. In addition, the Board's long-term workload continues to trend upward, despite VBA's many quality and service improvement initiatives, including the establishment of the Decision Review Officer program and greater cooperation between the regional offices and the BVA. The number of new appeals filed each year remains in excess of 60,000 and the number of substantive appeals filed is at least 32,000, most of which will eventually reach the BVA. In addition, there are thousands of cases remanded to the regional offices over the last several years and a majority of these will return to the BVA.

SUMMARY

Immediately after seeing the new Administration's budget request for FY 2002 and its recommendation of only a billion dollar increase in VA discretionary funding, National Commander Smith said, "The administration's suggested increase is simply not good enough."

The American Legion believes VA must receive at least $750 million more than the $1 billion in discretionary spending requested by President Bush and Secretary Principi. The American Legion specifically recommends the following minimal funding levels:

Medical Care	$21.6 billion
Medical and Prosthetic Research	375 million
Construction:	
Major	250 million
Minor	175 million
Grants for State Extended Care Facilities	80 million
National Cemetery Administration	115 million
State Cemetery Grants Program	25 million
VBA's General Operating Expenses	1.2 billion

If VA is to provide quality health care to America's veterans more funding is absolutely necessary. A billion dollars will not begin to address Hepatitis C treatment or long-term care mandated by the recently enacted Veterans' Millennium Health Care and Benefits Act. A billion-dollar increase will just about cover the on-going costs associated with maintaining current health care services, but there will be nothing left to address the claims adjudication crisis. VA must hire enough new claims adjudicators to expedite the delivery of benefits and replace the large number of retiring experienced adjudicators

This budget request is insufficient to fulfill the campaign promises made by President Bush, Vice President Cheney, and Secretary Principi to America's veterans and their families:

- Improve health care delivery,
- Modernize the claims process,
- Closer cooperation with TRICARE, and
- Full utilization of health care facilities throughout the system.

Mr. Chairman and Members of the Committee, adequate health care for veterans is important because veterans are important. Their sacrifice is the human cost of failed foreign policy. Whenever the VA budget suffers, it hurts America's veterans, and adversely impacts on their families. Many of you know of classic examples of your constituents that waited months, and sometimes years, for a claim to be processed. You know of others that must wait weeks, and sometimes months, for a medical appointment. Yet, when this Nation called on them to fight, their response was immediate!

Sadly, many veterans do not live long enough to see their claims resolved. Years of suffering, frustration, and financial hardship all too often follow them to their grave. The American Legion knows this is wrong and you know this is wrong. These problems cannot be properly resolved without adequate discretionary funding.

Thank you Mr. Chairman, this concludes my testimony.

Chairman SPECTER. Thank you very much, Mr. Fischl.

We now turn to Mr. Howie DeWolf, National Service Director for AMVETS.

Mr. DeWolf.

STATEMENT OF HOWIE DeWOLF, NATIONAL SERVICE DIRECTOR, AMVETS

Mr. DEWOLF. Mr. Chairman, members of the committee, I am Howie DeWolf, the National Service Director for AMVETS.

AMVETS is honored to join our fellow veteran service organizations in providing you with our best estimate of the resources necessary to carry out a responsible budget for the fiscal year 2002 programs of the Department of Veterans Affairs.

Mr. Chairman, I have submitted my written statement for the record and request that it be accepted, with your approval.

Chairman SPECTER. It will be made a part of the record in full.

Mr. DEWOLF. Thank you, sir. Sir, I will briefly summarize our recommendations as they pertain to the National Cemetery Administration. The three remaining Independent Budget veteran service organizations will follow me to cover the remainder of the document.

The Independent Budget veteran service organizations acknowledge the dedication of the National Cemetery Administration staff that provides the highest level of service to veterans and their families. To provide this service, they oversee an infrastructure of 119 National Cemeteries, and they perform over 77,000 internments yearly. With this level of effort, the addition of new cemeteries and the anticipated increased internment rate of the aging veteran population, the Independent Budget veteran service organizations recommend the following:

First, the National Cemetery Administration operating budget should be funded at $119 million for fiscal year 2002, a $10 million increase over 2001. This ensures our Nation's veterans are honored with a final resting place and lasting memorial to commemorate their service to our Nation.

Second, we recommend the State Cemetery Grants Program be funded at $30 million. The Grants Program provides funds to assist States in establishing, expanding, and improving State-owned cemeteries. We need to encourage their participation. Lack of participation is due in part to the low plot allowance of $150. We recommend it be increased to $600. Additionally, we recommend that the eligibility be expanded for all veterans who would be eligible for burial in a National Cemetery, not just those who served during wartime.

Finally, we recommend that the National Cemetery Administration establish a strategic plan for the years 2003 to 2008, the period of greatest demand, and that Congress make funds available for planning and fast-track construction of needed National Cemeteries.

We ask you to remember the service of all our Nation's veterans who have guaranteed our freedoms by honoring them with a final resting place and lasting memorials. Your support of proper funding for the National Cemetery Administration will help accomplish that goal.

The Independent Budget provides a well-developed and comprehensive summary of our recommendations to properly fund the Department of Veterans Affairs for the fiscal year 2002. By funding the budget's discretionary programs at $23.3 billion, you will assist greatly in ensuring veterans are provided the benefits they so rightly deserve for the personal sacrifices they have made on behalf of all Americans. That completes my statement, sir.

[The prepared statement of Mr. DeWolf follows:]

PREPARED STATEMENT OF HOWIE DEWOLF, NATIONAL SERVICE DIRECTOR, AMVETS

Mr. Chairman, Senator Rockefeller, and members of the Committee:

I am Howie DeWolf, National Service Director for AMVETS. AMVETS is honored to join fellow veterans service organizations in providing you our best estimates on the resources necessary to carry out a responsible budget for the fiscal year 2002 programs of the Department of Veterans Affairs.

AMVETS testifies before you today as a co-author of The Independent Budget. For over 15 years AMVETS has worked with the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars to produce an Independent Budget. This document provides our spending recommendations on veterans' programs for the new fiscal year. Besides working collaboratively on the overall publication effort, AMVETS' primary responsibility has focused on developing the recommendations in the National Cemetery Administration section of The Independent Budget.

Neither AMVETS nor I have been the recipient of any federal money for grants or contracts. All of the AMVETS activities and services are accomplished completely free of any federal funding.

Before I address budget recommendations for the National Cemetery Administration, I would like to say that AMVETS fully appreciates the strong leadership and continuing support demonstrated by the Senate Veterans Affairs Committee. AMVETS is truly grateful to the members who serve on this important committee. Clearly, you have at heart the best interests of veterans and their families and have distinguished yourselves as willing to work in a bipartisan manner to address numerous issues of great importance to the Nation's veterans.

Since its establishment, the VA National Cemetery Administration (NCA) has provided the highest standards of service to veterans and eligible family members in the system's 119 national cemeteries in 39 states, the District of Columbia, and Puerto Rico. Recently opened NCA cemeteries in Chicago, IL; Albany, NY; Cleveland, OH; and Dallas, TX., continue this tradition of remarkable achievement and service. Additionally, the NCA expects to begin the second phase of construction on four new cemeteries in 2001 and the completion of the planning process on a fifth.

While the National Cemetery Administration maintains more than 2.3 million gravesites in over 13,000 acres of cemetery land, there remains a need to establish additional national cemeteries in some critically needed areas. AMVETS supports the Committee's active review of encouraging the Administration to add more cemeteries to meet the growing demand for space. Clearly, without the strong commitment of Congress and its authorization, VA will likely fall short of burial space for millions of veterans and their eligible dependents.

The members of The Independent Budget recommend that Congress provide $119 million for the operational requirements of NCA in fiscal year 2002. Currently, the NCA averages more than 77,000 interments annually. The aging veteran population has created great demands on NCA operations. The NCA is a labor-intensive workplace. We believe that the continued high standard of service cannot be maintained without the provision of adequate resources of new staff and equipment improvements. $119 million for the NCA will provide the additional full-time employees and necessary supplies and equipment for grounds maintenance and program operations.

For funding the State Cemetery Grants Program, the members of The Independent Budget recommend $30 million for the new fiscal year. The State Cemetery Grants Program serves a critically important function working in complement with the National Cemetery Administration to encourage states to establish state veterans cemeteries. Through the State Grants Program, VA can provide up to 100 percent of the development cost for an approved cemetery project. This type of support can greatly assist in establishing gravesites for veterans in those areas where NCA cannot fully respond to burial needs.

To properly support veterans who desire burial in state facilities, members of The Independent Budget support increasing the plot allowance to $600 from the current, unreasonably low level of $150. In addition, we firmly believe the plot allowance should be extended to all veterans who are eligible for burial in a national cemetery not solely those who served in wartime.

Based on National Cemetery Administration statistics projecting a dramatic increase in the interment rate until 2010, members of The Independent Budget recommend that the National Cemetery Administration establish a strategic plan for the period 2003 to 2008. We must plan for a truly national system, and it must have congressional and administrative budgetary support. We call on Congress to make funds available for planning and fast-track construction of needed national cemeteries.

Mr. Chairman, this concludes my statement. I thank you again for the privilege to present our views, and I would be pleased to answer any questions you might have.

Chairman SPECTER. Thank you very much, Mr. DeWolf.

We turn now to Mr. Rick Surratt, Deputy National Legislative Director of the Disabled American Veterans. Thank you for joining us, Mr. Surratt, and the floor is yours.

STATEMENT OF RICK SURRATT, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. SURRATT. Good morning, Mr. Chairman. I am Rick Surratt with the Disabled American Veterans. My remarks today will focus on the budget and policy for the benefit programs, the DAV's primary area of responsibility in the Independent Budget. Also, because the President's budget does not offer details for us to address, I will highlight the IB recommendations for legislation and resources.

Typically, the administration's budget proposes a cost-of-living increase for compensation and dependency and indemnity compensation. The IB also recommends an increase to keep compensation in line with the increase in the cost of living.

To stay even with the cost of living, compensation must be increased by the same percentage as the annual rise in the cost of goods and services as measured by the Consumer Price Index. However, as temporary deficit reduction measures and to offset other spending, the COLA's have been rounded down to the nearest whole dollar. Regrettably, the new administration's budget continues the same old objectionable recommendation of prior administrations that you make this rounding down a permanent requirement.

Mr. Chairman, we are at a loss to find any legitimate reason for that recommendation. We all know that many disabled American veterans barely survive on the modest compensation they receive. It is bad enough to reduce benefits for disabled veterans in the name of budget reconciliation. But we simply cannot understand why the administration wants to take such advantage of our Nation's disabled veterans when no reason exists for doing so. To us, that certainly is not in keeping with the obligation this Nation has to care for those disabled in service to our country.

Fortunately, the President cannot do this without your concurrence. We look to you to make a strong statement that you will not move legislation for this purpose. We also urge you to reject the administration's proposal to make permanent the user fees and other temporary deficit reduction measures imposed upon veterans.

Now let me turn to the delivery of benefits. For years, VA has struggled to overcome poor quality and large backlogs in its compensation and pension claims processing system. Adequate resources are a central issue. In the IB, we recommend an additional $60 million to cover the cost of 830 new full-time employees for VA's compensation and pension service. VA desperately needs these additional employees to make up for unwarranted past reductions in staffing and to meet increased workload demands.

It also needs those employees to improve adjudicator proficiency and accountability and thus improve efficiency of the system. To do

this, VA needs not only to increase the number of decisionmakers, it needs employees to train adjudicators in the law and procedures, and employees to perform quality control reviews and enforce quality standards. These additional employees are absolutely essential to any hope of fixing the problems in VA's claims processing system.

Mr. Chairman, that concludes my statement. Thank you for allowing us to come before you today to offer our views on the fiscal year 2002 budget related matters. Certainly, I would be happy to answer any questions you may have.

[The prepared statement of Mr. Surratt follows:]

PREPARED STATEMENT OF RICK SURRATT, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Chairman and Members of the Committee:

I am pleased to appear before you on behalf of the more than one million members of the Disabled American Veterans (DAV) and the members of its Women's Auxiliary to discuss the fiscal year (FY) 2002 budget for the Department of Veterans Affairs (VA) and to present the alternative recommendations of the Independent Budget (IB).

This year marks the 15th year the DAV has joined with AMVETS, Paralyzed Veterans of America (PVA), and the Veterans of Foreign Wars of the United States (VFW) to assess the funding needs and make recommendations for veterans' programs. With the shared goal of ensuring that the needs of America's veterans are adequately addressed, we engage in this collaborative effort to present our collective views on policy questions, programmatic issues, and resource requirements for the effective and efficient delivery of benefits and services to veterans and their families.

The DAV has primary responsibility for the portions of the IB that deal with Benefit Programs, General Operating Expenses, and Judicial Review of Veterans Matters. My focus will therefore be on those areas of policy and the budget. The members of IB group appreciate the courtesy this Committee has extended by permitting us to present our views together in this format.

Because the President submitted only a broad budget outline without details, we are unable to compare in any depth his funding recommendations with our assessment of VA's resource needs. Unquestionably, his recommended $1 billion increase in discretionary budget authority will fall far short of what is necessary to maintain adequate delivery of benefits and services for veterans, however.

Similarly, the President's budget submission contains few details on the Administration's policy positions and legislative proposals for veterans' benefits. The narrative does indicate that the budget includes "several proposals" for legislation designed to "yield net mandatory savings totaling $2.5 billion over the next 10 years." According to the discussion, these several proposals comprise one to eliminate VA's vendee home loan program and other proposals to "extend permanently mandatory savings authorities that would otherwise expire over the next several years."

If it will result in savings, we have no objection to elimination of vendee loans. Vendee loans are those that VA provides to purchasers of properties VA has acquired by reason of default on guaranteed loans. We agree that such loans are outside VA's mission of providing benefits and services to veterans and their families.

However, we strongly oppose recommendations to permanently extend budget reconciliation measures that were enacted for a limited period to reduce budget deficits. Most of these measures adversely affected veterans. They reduced veterans' benefits or imposed upon them such things as user fees and co-payments. Especially repugnant is the one that requires rounding down compensation rates to the nearest whole dollar amount after adjustment for increase in the cost of living. Veterans have borne a substantial part of the burden of deficit reduction. No justification exists for permanently imposing these burdens upon veterans. We urge you, in the strongest possible terms, to reject these proposals as unfair, unwarranted, and unconscionable.

In the IB, we have presented several positive proposals to improve veterans' benefit programs to make them more effective and make them better meet veterans' special needs. For benefits funded under the compensation and pension appropriation, we recommended changes in law to:

• Provide a cost-of-living adjustment (COLA) for compensation and dependency and indemnity compensation
• Permit career military veterans to receive disability compensation and military longevity pay without offset
• Remove the offset between military nondisability separation, severance, or readjustment pay and disability compensation
• Permit veterans to recover taxes withheld on disability severance pay or exempt retired pay beyond the current 3-year period
• Include certain radiogenic diseases in the list of disabilities that may be presumed service connected on the basis of radiation exposure
• Presume all Vietnam veterans were exposed to herbicides containing dioxin
• Authorize presumption of service connection for amyotrophic lateral sclerosis affecting Persian Gulf War veterans
• Repeal the prohibition on service connection for smoking-related disabilities
• Authorize presumption of service connection for hearing loss and tinnitus for combat veterans and veterans that had military duties typically involving high levels of noise exposure
• Authorize temporary increases in compensation to be effective on the date of hospitalization or medical care that resulted in temporary total disability
• Restore the reimbursement for a headstone or marker acquired privately in lieu of furnishing a Government headstone or marker
• Increase the amounts of the burial allowances
• Permit payment of fees under the Equal Access to Justice Act to nonattorneys who successfully represent eligible VA claimants before the Court of Appeals for Veterans Claims

For readjustment benefits, the IB proposes legislation to:

• Permit refund of Montgomery GI Bill (MGIB) contributions when the individual becomes ineligible for the benefits by reason of a "general" discharge or a discharge "under honorable conditions"
• Increase the amount of specially adapted housing grants, provide for automatic annual COLAs, and authorize a grant for adaptations to replacement homes
• Increase the allowances for specially equipped automobiles to 80% of the average cost of a new automobile and to provide for automatic annual COLAs
• Increase the maximum home loan guaranty amount to $63,175

For veterans life insurance programs, the IB recommends legislation to:

• Exempt the cash value, dividends, or proceeds from consideration in determining entitlement under other Federal programs
• Authorize VA to revise its premium schedule for Service-Disabled Veterans Insurance to reflect current mortality rates

The IB also recommends repeal of the 2-year limitation on the payment of accrued benefits to survivors and repeal of the estate limitation for mentally incompetent veterans.

Without specifics, the Administration's budget indicates that it will provide the means to "rejuvenate" the VA's "efforts to ensure the timely and accurate processing of veterans' disability compensation claims." The budget states that it will "fully fund the Veterans Benefits Administration's (VBA) additional workload" from last year's legislation that restored the VA's "duty to assist" and the additional workload from a presumption of service connection for diabetes related to herbicide exposure. We support these recommendations in concept.

Problems with claims processing, accurate decisions, and timely benefits delivery have plagued and challenged VA for years. VBA has a number of initiatives and reforms under way to correct these problems. While Congress must hold VA accountable for effective and efficient administration of benefit programs, Congress must support VA with resources adequate to overcome past inefficiencies and to meet increasing demands. Without the necessary resources, the existing major problems will only grow worse.

To bring about positive change, VA must train both its new and experienced adjudicators in the procedural and substantive aspects of veterans' law without losing additional ground to the claims backlogs while adjudicators' time is spent administering or undergoing training. VA must increase staffing levels to meet the workload demands; it must devote sufficient time to claims development and analysis in decisions to allow for complete records, thorough reviews of the law and evidence, and well-reasoned, well-explained decisions. VA must devote additional resources to quality assurance, an area where its vigilance has been lacking and a crucial aspect of proficiency, performance, and accountability. VA is already understaffed in its claims processing personnel, yet it also desperately needs an infusion of substantial numbers of new employees to offset the expected retirement of many of its experienced adjudicators in the near future. Thus, a sizable number of additional full-time

employees (FTE) is essential to meet real needs and make up for past staffing reductions.

In the IB, we recommend that VA add 200 FTE to deliver training on a systematic and system-wide basis. We have recommend that VA add 170 new adjudicators to bring its staffing to the minimum level necessary to meet its workload demands. VA's appellate workload in field offices places great demands on its personnel. We recommend that VA add 200 new Decision Review Officers to address this appellate workload.

VA needs additional staff to perform quality reviews of the work of each of its claims adjudicators to assess performance, impose accountability, and remedy deficiencies on an individual employee level. Through its "Systematic Individual Performance Assessment" (SIPA) initiative, VA intends to review 100 decisions of each adjudicator per year. To accomplish this task, VA needs 260 additional new employees.

Accordingly, we have recommended that VA be authorized a total of 830 additional FTE for its Compensation and Pension Service in FY 2002.

Even with optimum quality, an irreducible number of errors are inevitable in a mass adjudication system as large and complex as VA's. With the necessarily and intrinsically complex statutes and regulations that govern disability and compensation issues, errors and legitimate differences of interpretation are unavoidable. In veterans' benefits, as it has often been acknowledged generally, law is not an exact science. The variables of human interactions and the corresponding nuances inherent in the factual bases on which legal rights rest require the intervention of human judgment. Such judgment is, of course, not infallible. Meaningful and effective judicial review is essential to maintain fairness and uniformity and to remedy the injustices that result from human error. To make judicial review a more effective enforcement mechanism for veterans, the IB recommends legislative changes in three areas.

First, we recommend a change in the legal standard under which the United States Court of Appeals for Veterans Claims reviews VA's findings of fact. In veterans' benefits law, the "benefit-of-the doubt" rule is a fundamental element of the process designed to favor veterans. This rule mandates that VA decide a factual question in favor of the veteran unless the evidence against the veteran is stronger than that supporting him or her. However, under its "clearly erroneous" standard of review, the Court allows VA's decision to stand unless a factual finding is without a plausible basis. The Court's lack of enforcement of the benefit-of-the-doubt rule nullifies and renders it meaningless. We have therefore recommended a change in the Court's standard of review to require that it set aside any finding of fact adverse to a veteran when the finding is not reasonably supported by a preponderance of the evidence.

Second, we recommend that the jurisdiction of the Court of Appeals for the Federal Circuit be expanded to permit it to review questions of law. Under its jurisdiction now, the Federal Circuit can review disputes involving the interpretation of a statute or regulation, but it cannot review ordinary questions of law decided in the first instance by the Court of Appeals for Veterans Claims. These questions of law arise when the Court of Appeals for Veterans Claims imposes its own new rule of law to govern a matter of substance or procedure. This situation presents an anomaly inasmuch as it insulates decisions on such questions of law from any appellate review whatsoever.

Third, we recommend that the law be amended to authorize a direct challenge in the Federal Circuit of VA's changes to its schedule for disability rating. Currently, VA regulations are subject to such direct challenge, but regulations in the form of rating schedule changes are immune to such challenge. That means there is no remedy for changes to the rating schedule that are clearly unlawful or arbitrary and capricious. No unlawful or arbitrary and capricious regulation, especially one governing disability rating, should be immune to correction. As it should, this very narrow basis for challenge would leave protected VA's lawful exercise of discretion in establishing disability rating criteria.

We hope our analyses of these issues and VA's funding needs will be helpful to you. We appreciate the opportunity to present our views, and we thank this Committee for its continuing support of our Nation's veterans.

Chairman SPECTER. Thank you very much, Mr. Surratt.

We now call upon Mr. Harley Thomas, Health Policy Analyst, Paralyzed Veterans of America.

Mr. Thomas.

STATEMENT OF HARLEY THOMAS, HEALTH POLICY ANALYST, PARALYZED VETERANS OF AMERICA

Mr. THOMAS. Good morning, Mr. Chairman. On behalf of the Paralyzed Veterans of America and the Independent Budget, it is indeed a pleasure to give our views and estimates on the Independent Budget's health care budget for fiscal year 2002 for the Department of Veterans Affairs.

The Independent Budget recommends for fiscal year 2002 a $2.7 billion increase for VA medical care. For fiscal year 2002, the Independent Budget estimates that uncontrollables such as salary increases and inflation increases alone will require an increase of $1.3 billion.

In addition, the IB has identified a necessary increase of $848 million to cover the costs of institutional and noninstitutional long-term care initiatives mandated by the Veterans Millennium Health Care and Benefits Act.

Over the past 5 years the capacity of the VA to provide SCI care has been seriously degraded by substantial staff reductions, despite the mandate instituted by the 1996 Congress to maintain system capacity. Local hospital officials reduced SCI staff to a point that they could only operate about 65 percent of the SCI/D beds reported as operational in 1996. Last year, the VA issued a directive establishing a minimally acceptable level of staffing and staffed beds at each SCI center, and issued a memorandum regarding the need for local managers to identify and provide additional resources required to restore the mandatory staffing levels.

Based upon actual site inspections, we have identified the need for at least 212 FTEE's which would allow for full staffing of SCI beds. We have identified the need for 128 specialty nurses, 19 psychologists, 47 PT's, and 7 social workers. Additionally, we believe there should be an increase of at least 11 medical doctors with SCI specialty. The IB has requested $25 million additional in funding to begin this restoration work.

The IB has estimated increased costs of pharmaceuticals will total $65 million because of increased patient load projected by the VA.

The IB recommends $100 million increase for mental health programs, a first step in a 3-year recommendation to add a total of $300 million to these vital programs.

The IB has recommended an increase for Medical Administration and Miscellaneous Operating Expenses of $12 million, bringing this account up to $74 million.

We also advocate $45 million to increase the Medical and Prosthetic Research Program account, up to $395 million.

On February 28, the President released his Administration Blueprint for New Beginnings. A $1 billion increase, of course, will not fully be realized by the veterans' health care. Traditionally, only approximately 90 percent of discretionary increases accrue to health care. As I stated before, the VA requires at least $1.3 billion increase just to keep pace with 2001. This means that the President's budget blueprint falls far short of what is required to maintain the status quo.

We recognize this committee does not appropriate dollars, but you do authorize them. You serve as a resource and as an advocate

to the appropriators as they fashion budget policy. The authorization process must recognize the real resource requirements of the VA. We look to you, and to your expertise in veterans' issues, to help us carry forward this message to your colleagues and to the public.

That concludes my statement.

[The prepared statement of Mr. Thomas follows:]

PREPARED STATEMENT OF HARLEY THOMAS, HEALTH POLICY ANALYST, PARALYZED VETERANS OF AMERICA

Chairman Specter, Ranking Minority Member Rockefeller, members of the Committee, the Paralyzed Veterans of America (PVA) is honored, on behalf of our members and the Independent Budget, to present our views on the Department of Veterans Affairs' (VA) budget for fiscal year (FY) 2002. We are proud to be one of the four co-authors, along with AMVETS, the Disabled American Veterans, and the Veterans of Foreign Wars, of the 15th Independent Budget, a comprehensive policy document created by veterans for veterans.

The Independent Budget is an annual budget and policy review for veterans programs and represents an unprecedented joint effort by the veterans' community to identify the major issues facing the veterans' community today while serving as an independent assessment of the true resource and policy needs facing veterans. It is our distinct pleasure, once again, to be responsible for the health care recommendations and analysis, and I shall address these in my testimony today.

The VA medical system is a national asset. After years of chronic under-funding and fiscal neglect, the VA has seen budget increases for the past two fiscal years. It is essential that the health care increases realized over the last two years be continued in FY 2002. There must be continued and sustained investment in the national resource which is the VA health care system, investment in protecting and strengthening specialized services and in improving access and ensuring that the infrastructure exists to provide first-rate health care, as promised by the President and sought by our members.

To accomplish these goals, the Independent Budget recommends, for FY 2002, a $2.7 billion increase for VA medical care.

Every year, the VA requires additional funding in order to remain in the same place it was the previous year. This additional funding is required because of mandatory salary increases and the effects of inflation. For FY 2002, the Independent Budget estimates that these "uncontrollables" will require an increase of $1.3 billion.

In addition, the Independent Budget has identified a necessary increase of $848 million to cover the costs of institutional and non-institutional long-term care initiatives mandated by the Veterans Millenium Health Care and Benefits Act (P.L. 106–117) enacted last Congress.

This $848 million represents start up costs for the long-term care initiatives established in the Millennium Act two years ago that have yet to be implemented. The VA has a responsibility, and an historic duty, to meet the long-term care needs of an aging veteran population. It has the opportunity to do so in the most cost-effective and appropriate way by implementing the community and home-based care programs called for in the bill. It can also show that it can become a leader in the United States in providing long-term care in a country that has no broad based long-term care programs for older Americans and all Americans with disabilities.

The remainder of the recommended increase, $523 million, is slated to fund vitally needed initiatives. These initiatives include restoring spinal cord injury/dysfunction capacity, meeting the challenge of rising pharmaceutical costs, and maintaining VA capacity for mental health services.

Over the past 5 years the capacity of the VA to provide SCI care has been seriously degraded by substantial staff reductions despite the mandate instituted in 1996 by Congress to maintain system capacity. Local hospital officials reduced SCI staff to a point that they could operate only 65 percent of SCI/D beds reported as operational in 1996. Last year, the VA issued a directive establishing the minimally acceptable level of staffing and staffed beds at each SCI Center, and issued a memorandum regarding the need for local managers to identify and provide additional resources required to restore the mandatory staffing levels. The Independent Budget has requested $25 million in additional funding to begin this restoration work.

We have all read the news stories concerning the increased costs of pharmaceuticals faced by our citizens. The Independent Budget has estimated that these

increased costs will total $65 million because of the increased patient load projected by the VA.

The Independent Budget recommends a $100 million increase for mental health programs, a first step in a three-year recommendation to add a total of $300 million to these vital programs. We have witnessed an unprecedented erosion of the VA's capacity to provide specialized treatment within distinct dedicated programs for veterans with serious mental illness, substance-abuse problems, and post traumatic stress disorder. Extensive closures of specialized inpatient mental health programs, coupled with slashed budgets, have lead to the emergency situation faced by these vital programs. These programs must be protected and expanded in order to meet the needs of veterans.

The Independent Budget has recommended an increase for Medical Administration and Miscellaneous Operating Expenses (MAMOE) of $12 million, bringing this account up to $74 million. Funding shortfalls in the MAMOE account have left the VA unable to adequately implement quality assurance efforts or to provide adequate policy guidance within the 22 Veterans Integrated Service Networks (VISN). Veterans Health Administration headquarters staff play the essential role of providing leadership, policy guidance, and quality assurance monitoring under the decentralized VA health care system. It is important that these important roles be strengthened.

Another important asset of the VA is its Medical and Prosthetic Research Program. VA research plays a critical role in attracting first-rate clinicians to practice medicine and conduct research in VA health care facilities, keeping veterans' health care at the cutting-edge of modern medicine. Advancements in medical treatment and technology developed in VA hospitals and laboratories have revolutionized modern health care and pioneered advances that are sustaining the health and quality of life of veterans and all Americans. As has been stated, "today's research indeed creates tomorrow's health care."

With the bipartisan push to increase research funding for the National Institutes of Health (NIH), to double its funding over the course of five years, the VA Medical and Prosthetic Research program must not be left behind. The President is seeking a $2.8 billion increase for the NIH. VA research is an important component of our national research effort. The Independent Budget advocates a $45 million increase to bring this account up to $395 million.

The President, on February 28, 2001, released his Administration's "Blueprint for New Beginnings." PVA has many questions concerning the Administration's plans for the VA. Although we were heartened by the fact that the Administration has proposed an increase in discretionary spending for the VA, this "Blueprint" raises more questions than it answers. We look forward to seeing the full scope, and the complete rationale, of the Administration's FY 2002 budget request for the VA in April.

The President's "Blueprint" trumpets a discretionary spending increase for veterans of $1 billion. This $1 billion increase, of course, will not be fully realized by veterans' health care. Traditionally, only approximately 90 percent of discretionary increases accrue to health care. As I stated before, the VA requires at least a $1.3 billion increase just to keep pace with FY 2001. This means that the President's budget "Blueprint" falls short of what is required to maintain the status quo of the health care system for this coming year.

In addition, any additional funding needed to address claims backlogs will come at the expense of VA health care because these additional funds would lay claim to the finite pot of discretionary spending. It is essential that the claims process be fixed—we have argued for years that a benefit delayed is a benefit denied—but this vital work must not come at the expense of sick and disabled veterans.

The "Blueprint" assumes a transfer of health care liabilities. The Administration may argue that the increase for VA health care will be higher because of its assumption that $235 million in VA health care "liabilities" will be shifted to the Department of Defense (DOD). This will be implemented by proposed legislation that would mandate that veterans choose either DOD or VA to receive their health care. The budget assumes that 27 percent will switch to the DOD. There seems to be no justification for this percentage, and we have questions concerning how the figure of 27 percent was settled upon.

The President's "Blueprint" assumes that the VA will realize "net mandatory savings totaling $2.5 billion over the next 10 years." The OBRA Extenders are slated to save $2.3 billion over ten years and the elimination of the VA's vendee home loan program is slated to save $228 million over the same time frame. None of these savings are available for FY 2002, and, in fact, eliminating the vendee home loan program is estimated to cost $19 million in FY 2002. Finally, these savings would not be available for discretionary programs unless budgetary legerdemain is employed.

PVA awaits the final budget numbers to ascertain the role played by the Medical Care Collections Fund (MCCF) in any of these projections. As we have stated in the past, and firmly hold today, these funds should be used to augment, not replace, appropriated dollars to enhance the health care provided to veterans. The inflated collection estimates have never been reached in the past, and, in fact, have steadily declined each year since 1995 despite highly exaggerated yearly estimates of soaring receipts. Veterans should not be forced to pay the price for these failures to reach these rosy estimates.

The President's "Blueprint" states that the "VA has begun the assessment phase of an infrastructure reform initiative that will result in a health care system with enhanced capabilities to treat veterans with disabilities or lower incomes living in underserved geographic areas. Savings from the disposal of underused VA facilities will support these improvements." We await the details and we urge caution. It is not clear how, in a budget sense, these savings will be realized and directed to VA health care. We applaud the President's desire to protect and augment the VA's core missions, but we insist that the needs of veterans, not the needs of budgets, must come first.

We believe that the Administration's "Blueprint" is a step in the right direction, but much more is needed, and much more must be done.

We recognize that this Committee does not appropriate dollars, but you do authorize them. You serve as a resource, and as advocates, to the appropriators as they fashion budgetary policy. The authorization process must recognize the real resource requirements of the VA. We look to you, and your expertise in veterans' issues, to help us carry this message forward, to your colleagues and to the public.

We need your help, and we offer our assistance, to ensure that the VA receives the funding it needs to ensure that veterans receive the health care they have earned, and the health care they have been promised. Let us move forward from our accomplishments of the last couple of years and build a strong, and continuing base, for the national asset that is the VA.

On behalf of the co-authors of the Independent Budget, I thank you for this opportunity to testify concerning the resource requirements of VA health care for FY 2002. I will be happy to answer any questions you might have.

Chairman SPECTER. Thank you very much, Mr. Thomas.

And now we recognize Mr. Cullinan, Director of the National Legislative Service, Veterans of Foreign Wars.

Mr. Cullinan.

STATEMENT OF DENNIS M. CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. CULLINAN. Good morning, Mr. Chairman. On behalf of the entire VFW membership, I thank you for including us in today's most important discussion of funding for the Department of Veterans Affairs.

The authorizing/oversight activities of this Committee are paramount to the effective and compassionate operation of the VA. We thank you for past accomplishments, and we look forward to working with you into the future.

As in the past, the VFW has dealt with the construction portion of the VA budget, and I will now briefly turn to the main points of my oral statement.

Past year shortfalls in construction funding, even as the population of sick and elderly veterans is rapidly on the rise, have seriously eroded VA's ability to sustain a physical plant adequate to meeting veterans' needs. Major and minor construction projects funding has plummeted dangerously since fiscal year 1993 to the current fiscal year, from $600 million to just over $200 million. Among other things, this has resulted in an untenable backlog of nonrecurring maintenance needs that have not been adequately funded under the medical care account.

For major construction, we recommend an increase of $308 million, for a total funding level of $374 million. This increase is needed for a major portion of the seismic correction needs of $250 million, such as the one that needs to be carried out at Palo Alto VAMC.

An increase of $265 million to the minor construction account is recommended, for a total funding level of $431 million. This increase will support inpatient and outpatient care delivery infrastructure improvements, research facility upgrades, and a historic preservation initiatives.

VA must be provided with the requisite dollars to update facilities and services for women veterans. All necessary steps must be taken to ensure their privacy and comfort at VA facilities. Women in uniform have continued to serve with distinction, and they deserve the very best from us.

In another area, while we of the VFW and the IB applaud congressional and VA efforts to more effectively configure and apply existing resources so that more veterans may be better served, resources must be placed in response to need, not circumstance or expediency. We are deeply concerned, however, that as VA attempts to achieve this objective through implementing its CARES process, it does not result in a de facto moratorium in needed construction and renovation projects. There are, and will continue to be, certain projects that need to be completed well in advance of the conclusion of the CARES process, and we urge that this happen.

Mr. Chairman, this concludes my statement. Thank you.

[The prepared statement of Mr. Cullinan follows:]

PREPARED STATEMENT OF DENNIS M. CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. Chairman and members of the committee:

This year, as in the past, Mr. Chairman, the Veterans of Foreign Wars of the United States is proud to be one of the co-authors of the Independent Budget. Our primary responsibility is for the Construction Programs and my remarks will be focused on that major area.

The capacity to provide timely access to quality care for service disabled and low income veterans, while further transforming the VA into the health care provider of choice for those veterans whose cost of care can be covered by third party payers, symbolizes an acknowledgement of the special debt of gratitude owed by our nation to those who faithfully served to ensure our freedom and security. That this unique system of delivering health care to America's veterans has undergone a major transformation is in itself a major understatement. The many milestones that have marked the VA health care system during the past decade have had the ironic effect of both helping in its transformation into a world-class medical system, while at the same time placing it in a dilemma that can potentially lead to the deterioration of the system and, eventually, to its inexorable collapse.

Succeeding Administrations and Congresses have promulgated numerous measures that have made possible the significant improvements of the system. These efforts, however, have been neither sufficiently consistent nor amply sustained to ensure the Veterans Health Administration timely evolvement into a streamlined, cost-effective provider of health care that will stay ready to change with the times. The present condition of the substantial capital assets held by the VA, through which it is expected to deliver most of the services it's mandated to provide to veterans and their dependents and survivors, stands out as a glaring example of the deleterious consequences of an on-again-off-again approach to funding VA programs.

The improvements in VA health care, coupled with the advancing age of the entire veterans population, have resulted in a substantial increase of the number of veterans seeking services from the system. At the same time the level of investment in maintaining the physical infrastructure, through Major and Minor Construction projects, has plummeted dangerously since fiscal year 1993 to the current fiscal

year, from $600 million to just over $200 million. Understandably, the focus of construction projects has had to change from one of building large centralized physical plants to a design of having more access points to state of the art facilities that can provide primary and specialty care, backed by centers of excellence ready to provide more complex care for acute and chronic or long-term ailments. But this strategy has been weakened by the lack of consistent funding. In addition to the lack of attention to the construction needs, this neglect has created an untenable backlog of non-recurring maintenance needs which have not been adequately funded under the medical care account.

VA must maintain and improve its existing facilities to support delivery of veterans' benefits and health care services, while protecting the nation's investment by assuring the continued viability of this infrastructure. The ongoing evaluation under the Capital Assets Realignment for Enhanced Services (CARES) to design a reconfiguration of the Department's physical plant that will free up—or generate new—resources to provide more timely access to quality care for more veterans, while a worthy effort, should not be an impediment to meeting ongoing construction and maintenance needs. Regrettably, the defacto moratorium on funding already approved construction projects since the start of the CARES studies has further exacerbated the manifest lack of stewardship of the system's facility assets.

As the Committee is well aware, an independent study by Price Waterhouse concluded that the VA should be investing an amount equal from 2 to 4 percent of the value of its facilities to improve and update them. It recommended a similar amount annually for non-recurring maintenance. Not to do so would amount to a plan for the deterioration of the system that would lead to its closure. We are much encouraged, Mr. Chairman, by the legislative measure you—along with Messrs. Evans, Moran and Filner—have introduced to address this and the other construction concerns cited in the Independent Budget.

The construction needs of the VA are evident, and can only be missed—or ignored—by those who would like to see the Veterans Health Administration deteriorate out of existence. Men and women of good will, both in Congress and throughout the nation, want to see the right thing done. As daunting as the funding requirements to meet these needs may seem, a strategic approach would validate the need for a major investment today that would save much unnecessary waste in the future. The demonstrated need for a $30 million project in Veterans Integrated Service Network 1, which would facilitate the consolidation of certain services in the Boston area, resulting in an annual operating savings of $50 million, is a poignant example of how the current approach to approving and funding VA construction needs is seriously flawed. Failure to realize these improvements since they were first identified in 1998 will cost the VA over $100 million in extra operating costs. This is just not a good way to run a business. It is, particularly, not the way to care for the trust placed on the Administration and Congress by America's taxpayers.

As we are all well aware, the VA has an inventory of seismic improvement projects that continue to go unfunded. Just in the last budget cycle, Congress failed to fund a much-needed seismic project in the Palo Alto VA Medical Center at a cost of $26.6 million. The critical nature of this need was, ironically, poignantly underscored on the same day the President released his budget proposal, when the 6.8 magnitude earthquake in the state of Washington damaged two buildings at the American Lake VA Medical Center resulting in the temporary evacuation of many of the patients. These buildings were part of the VA inventory of seismic needs. While we are relieved that the damage wasn't extensive, and no one was injured, the timing would seem almost providential. We should all be thankful that, by Divine grace, the earthquake did not occur hundred miles to the south at that other more seismically unstable area where the Palo Alto facility is located. But, this is a warning that should not go unheeded.

Continued neglect of all the VA construction needs constitutes a tragic mismanagement of what is the free world's most cost-effective system for delivering quality health care, education, research and pioneering in the delivery of medical care and rehabilitation. Moreover, not allowing the system to go beyond the threshold, at which it is presently poised, of fulfilling its potential for being all that it can be in serving America's veterans, would be tantamount to squandering what is a national health care treasure that indirectly benefits all citizens.

In order to prevent this tragic consequence, the Independent Budget recommends a total funding level for construction in Fiscal Year 2002 of $804 million as a down payment to complement the total transformation of the Veterans Health Administration into a more agile and cost effective deliverer of quality health care for today and tomorrow's veterans.

For Major Construction, we recommend an increase of $308 million, for a total funding level of $374 million. This increase is needed for a major portion of the seismic corrections needs of $250 million.

An increase of $265 million to the Minor Construction account is recommended, for a total funding level of $431 million. This increase will support inpatient and outpatient care delivery infrastructure improvements, research facility upgrades, and a historic preservation grant program that will protect the VA facilities which are part of the historical heritage of our nation. We also recommend that the current $4 million ceiling authority for Minor Construction projects be increased to $16 million. The current limitation results in a piecemeal approach to design and completion of projects that adds delays, facility disruptions and promotes poor fiscal management practices.

Other programs covered by the Independent Budget with recommended construction funding increases include grants for construction of state extended care facilities and state veteran's cemeteries. In addition, we are recommending an increased funding in the medical care account for nonrecurring maintenance to the level of $391 million. This would be a modest step in the right direction towards addressing the considerably higher funding needed to address the problems cited in the Price Waterhouse report.

Finally, Mr. Chairman, the Independent Budget calls for Congress to provide sustained support for Major and Minor Construction so that planning and design for future projects can continue without interruption.

Mr. Chairman, this concludes my statement. I will be happy to answer any question you or members of the Committee may have.

Chairman SPECTER. Thank you very much, Mr. Cullinan.

I regret that there is not time for questioning. I just have a few minutes left on a vote which is now pending. But the committee very much appreciates your coming forward to testify, and we very much appreciate the work that you do for the veterans.

Just a personal note from me. My father was a veteran of World War I. He served in the Argonne Forest and was wounded in action. I recall living in Wichita, KS, and how my father received benefits from the Veterans Administration Hospital there for the wounds he sustained and also for nonservice-connected injuries. He was severely injured when a spindle bolt broke on a pickup truck, a brand new pickup truck, that rolled over and crushed his right arm. So, in addition to the disability of his legs, he had metal wires put in his arm, which was the best they could do for him at that time. So when I hear of cutting back on nonservice-connected help for veterans who are in need, and this was 1937, in the midst of the Depression, I am very much concerned.

We will be submitting questions to you for the record. This committee will take a very, very close look at the budget submissions. We are mindful of the increase which has been requested already by the House Committee and I have talked to Chairman Smith about that directly. And we will be reviewing other sources of income. And as you know, this committee was instrumental, as was this Senator, in an increase of $1.4 billion last year, and $1.7 billion the year before.

Without objection, Senator Rockefeller's statement will be made a part of the record.

[The prepared statement of Senator Rockefeller follows:]

PREPARED STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM WEST VIRGINIA

The Congress faces tremendous challenges this year, as we begin the budget process without any of the detail that usually accompanies the President's budget. Indeed, I understand that VA may not be able to provide more information until sometime in April, long after the Committee will have provided its required input to the Budget Committee. It is, therefore, vitally important that we use our time wisely

this morning to learn as much as we can about VA's needs, and how the President's budget proposes to meet those needs.

While we currently lack the details of the President's submission, the proposed budget provides for a net discretionary increase of $1 billion, or 4.5 percent, above the FY 2001 level. Notably, the consortium of veterans services organizations that authors the Independent Budget for Fiscal Year 2002 recommends an increase of $3.5 billion over FY 2001 funding.

We haven't been provided with information about how the President's proposed $1 billion is to be allocated among the various accounts. Clearly, though, the amount requested for the health care system is far from adequate. If the appropriation is actually less than $1 billion more than last year, I believe we can expect to shrink the system, to contract out for more and more care, to reduce staff, and to slash programs. These reductions would be occurring at a time when vast numbers of our veterans are in need of long-term care and specialized services, and they are increasingly turning to the VA health care system for care. The situation is tenuous, at best.

I have no doubt that the proposed budget would have a devastating effect on our four West Virginia VA Medical Centers. In spite of the decrease in the total number of veterans statewide, more and more West Virginia veterans are turning to the VA for care. For example, the Martinsburg VAMC has had an increase in new enrollees of 25.8 percent over the last two years. Expanded enrollment at all four medical centers has resulted in financial crises, threatening their ability to provide high quality care in a timely fashion.

What level of funding is appropriate for the VA in the coming fiscal year? We need to understand what is required to deal with the impact of inflation, to fund existing initiatives, and to move forward in the ways we all want the system to go.

There are many reasons to provide additional funds for VHA medical care. Landmark legislation signed into law late in 1999 significantly increases noninstitutional long-term care, which for the first time is available to all veterans who are enrolled with the VA health care system. While I am enormously proud of this legislation, there is no doubt it is costly, as are all long-term health care expansions. Providing long-term care to all Americans is a priority; VA can begin this effort for our Nation's veterans, but it must have sufficient funds to do so.

The Millennium Act also ensures emergency care coverage for veterans who have no other health insurance options. This is a costly, but necessary provision: nearly 1 million veterans enrolled with the VA are uninsured, and they are in poorer health than the general population. While this legislation has not yet been implemented or publicized, the claims for this new benefit are already mounting and will require substantial new resources.

VA must also contend with higher expenses of medical care caused by inflation and wage increases, which are estimated to cost nearly a billion dollars annually. Between these two large-scale initiatives—long-term care and emergency care coverage—and simply maintaining current services, we know that we must meet a minimum funding threshold. The President's entire discretionary increase would not be sufficient to cover these baseline costs.

Simply maintaining current services may not be enough to ensure that VA can meet the health care needs of veterans. Chronic illnesses of the aging veterans population and newly recognized challenges—such as the need to shape new programs for veterans affected by Hepatitis C—will further strain VA's resources. We must anticipate increased and changing demands for treating complex diseases, such as HIV and Hepatitis C, and ensure that veterans with multiple, overlapping medical problems receive all the treatment that they need.

What level of funding is needed for VA to develop consistent outcome measures for specialized services, or to restore the capacity for PTSD and substance abuse treatment to the legislatively mandated level? In West Virginia, many veterans not only wait months and months for specialty care, but have to travel hundreds of miles to get it. While opening community outpatient clinics has allowed VA to increase veterans' access to primary health care, we must ensure that the many veterans who require more intensive specialized services can turn to adequately funded inpatient programs.

VA has been progressing slowly toward equitable payment for care in state veterans homes, the largest providers of long-term nursing care in the United States. Without an increase in the budget, can we expect VA to adequately staff its State Home Program office, or adequately support nursing and domiciliary care?

VA research not only makes a major contribution to our national effort to combat disease, but also serves to maintain a high quality of care for veterans through its impact on physician recruitment and retention. The proposed budget would allow, at best, for a stagnant research budget. Not only might this hamper VA researchers

in their search for new and better medical treatments, but it could weaken efforts to protect human subjects in VA-sponsored studies. The Independent Budget suggests that an increase of $45 million will be required merely to offset the costs of inflation and increasingly stringent research guidelines.

There are certainly savings to be gained through resourceful management of VA hospitals and clinics, and VA is pursuing this possibility through the Capital Asset Realignment and Enhancement Studies (CARES). However, I am resolved that efficiencies not come at the expense of veterans who turn to the VA health care system for needed treatment. It is imperative that VA not neglect essential repairs and maintenance of its infrastructure while awaiting the outcome of the CARES process. A shortsighted focus on immediate gains from halting necessary construction, or from failing to preserve existing facilities, will most likely prove costly to VA and veterans in the long run.

I realize that there may be budget constraints on VHA's ability to carry out its many missions, but we must know what the impact would be of funding at different levels. Only then can we make informed choices.

Clearly, there is also a need for a focused, sustained effort to improve claims processing and other activities within VBA. Again, we need to know what level of funding is needed.

We already know that VBA needs a significant increase in staffing to eliminate its increasing backlog. New legislation reestablishing the duty to assist, regulations presumptively connecting diabetes to Agent Orange exposure in Vietnam veterans, and new software systems have severely affected VBA's workload and slowed output. West Virginia veterans are already receiving letters from the Regional Office warning them to expect a 9–12 month delay for initial consideration of their claims.

If VBA is unable to hire new staff and continue with its technology pilot programs, the backlog of claims is expected to grow from the current 400,000 claims (up from 309,000 in September 2000) to 600,000 by March 2002. We need to make certain that VBA receives sufficient funding to deal with this crisis.

VBA also faces an aging workforce, with projections that 25 percent of their current decisionmakers will retire by 2004. These losses would be in addition to the staff that has already left service. It takes 2–3 years to fully train a new decisionmaker. Therefore, it is critical that VBA hire new employees now to fully train them before the experienced trainers and mentors have retired.

We cannot forget our commitment to provide a final resting place of honor for our Nation's veterans. Sadly, the aging of our veterans population has created great demands on the National Cemetery Administration, and projections suggest that the need will continue to grow, peaking in 2008. We must act quickly to ensure that we are prepared to meet this solemn duty. How much funding will be required to maintain the current facilities, to implement fully the National Shrine initiative, and to fund construction of the six new cemeteries authorized by Congress in 1999?

While Congress is deciding how to cut taxes responsibly, we mustn't lose sight of our other critical priorities. We all need to agree on how much goes to tax cuts and how much should be saved to strengthen Medicare, invest in education, and fully address the needs of the men and women who have served our Nation. The budget before us does not fully recognize our responsibility to this Nation's veterans and their families. I will be working to make sure that it does.

Chairman SPECTER. As I say, we will be submitting questions for the record to you gentlemen, also to the Secretary.

Thank you for coming this morning.

That concludes our hearing.

[Whereupon, at 11:10 a.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

PREPARED STATEMENT OF RICHARD WEIDMAN, DIRECTOR, GOVERNMENT RELATIONS, VIETNAM VETERANS OF AMERICA

Mr. Chairman, on behalf of Vietnam Veterans of America (VVA), I thank you and your distinguished colleagues for the opportunity to express our views for the record in regard to the President's proposed FY 2002 budget for the United States Department of Veterans Affairs (VA).

While we appreciate President Bush speaking with emphasis about the nation's responsibility toward veterans in his recent address to Congress, a one billion dollar increase in discretionary spending at VA is not an acceptable increase. VVA is very concerned about the effects of this grossly inadequate proposal will have on vitally needed services for veterans. VVA is equally concerned about accountability; will the resources made available by Congress be utilized for maximum impact, and will VHA actually spend funds in the manner directed by Congress.

The rate of medical inflation in the United States varies from about 8–12 percent (+) per year. An $800 million dollar increase for the Veterans Health Administration (VHA) from FY 2001 to FY 2002 is represents a 4 percent increase. In other words, the administration's proposal for VHA is less than half of the conservative estimate of what VHA simply to maintain its ability to serve veterans. Congress can and must do better than this.

Vietnam Veterans of America enthusiastically endorse the Independent Veteran Service Organization (IBVSO) budget. At least $1.7 billion in additional funds over the FY 2001 level is needed in the VHA just to keep up with inflation. This level of funding for VHA does not address the need to restore the organizational capacity to serve veterans that was lost because of flat-lined appropriations in FY 1996, FY 1997, and FY 1998.

Specialized care services at VHA (e.g., spinal cord injury treatment, blind & visually impaired services, Post-Traumatic Stress Disorder (PTSD) treatment programs and services have all been dramatically eroded in the past five years. When the Veterans Eligibility Reform Act was enacted in 1996, Congress mandated that the level of resources and capacity to deliver the specialized services, which is really the heart of the VHA mission, be maintained at least at the FY 1996 level of effort. That has not happened. Rather, such services have been diminished and truncated due to a lack of resources and a lack of emphasis on these programs by key managers at the VHA the local health care delivery level, the Veterans Integrated Services Network (VISN) level, and at the national level.

One example of this diminishment of services is to the Seriously & Chronically Mentally Ill (SCMI) patients, which includes Post-Traumatic Stress Disorder (PTSD) treatment and substance abuse treatment. The funding for SCMI has dropped dramatically below the funding provided in FY 1996. At least five VISNs have no inpatient or resident treatment for chronic, acute PTSD. Substance abuse treatment programs have disappeared or been dramatically cut. Yet VA maintains that they are in compliance with the capacity requirements of the 1996 law.

The General Accounting Office (GAO) has determined that the management information systems and documentation of where it spends resources (much less the outcomes and results for the veteran) are woefully inadequate or non existent. VVA believes that even without adequate systems it is clear that VA is not in compliance with the 1996 law and needs to move to restore needed capacity, particularly in the specialized services.

Therefore, VVA recommends that an average of $1 billion per year be dedicated to restoration of vitally needed organizational capacity in VHA. This would probably be $600 million the first year, $1 billion the second year, and $1.4 billion the third year. The overwhelming majority of these funds (75–90 percent) would go to specialized services, with the balance going to staffing needs in acute care areas such as hepatitis C.

It is the belief of Vietnam Veterans of America that centralized control of funding is required in the specialized services and in some other key areas. The decentralized allocation of funds to the VISNs for the past five years has resulted in dramatic reductions in specialized services. After the flood of complaints of denial of service from veterans who needed prosthetics to Congress, and the resulting seeming inability of VHA central management to win cooperation of the VISN Directors, it was determined that the only way to ensure that veterans could get proper prosthetics services, no matter where they lived in the United States, was to centralize the funding. That effort has been successful.

VVA believes that the same centralized control of funding is necessary for all specialized services and other key areas, such as services to homeless veterans, and outreach, testing, and treatment of hepatitis C. This requirement for centralized control can be removed once the VHA has actually developed a sensible and workable computerized management information system, and has proven that there is a working system for holding VISN directors and other managers truly accountable for results and performance of the right measures.

Although VHA has done a great deal to address hepatitis C in terms of national policy, there still has not been the kind of outreach, testing, treatment, and case management program, on a consistent facility to facility basis that is needed. Nor has there generally been proper moves to acquire new staff at the medical center level needed to deal with the more than 70,000 veterans who have tested positive for the hepatitis C virus, even with only sporadic testing and virtually no outreach. Congress appropriated $350 million to deal with this problem, but VHA cannot account for these funds. The same could be said about any of the specialized services.

The bottom line is that VVA recommends a minimum of at least $2.3 billion in discretionary funding be appropriated to VHA over the FY 2001 level, with special tight controls over at least $ 600 million of these funds to ensure that these funds are utilized as intended by Congress (for the restoration of vitally needed organizational capacity, mostly in specialized services and the VA Vet Centers).

READJUSTMENT COUNSELING SERVICE (RCS) VET CENTERS

Readjustment counseling is provided through a national system of 206 community-based Vet Centers. The Vet Centers are located outside of the larger medical facilities, in easily accessible, consumer-oriented facilities highly responsive to the needs of the local veterans. For many veterans who would not otherwise receive VA assistance, the Vet Centers are the community-access points for VA healthcare. Vet Centers also prioritize care to high-risk groups such as minorities, women, disabled, high combat exposed, rural and homeless veterans. Comprising a unique more-than-medical VHA program, Vet Centers report to the Chief Readjustment Counseling Officer at VA Headquarters. Locally, the Vet Centers function in full partnership with the medical facilities in each of the 22 VISNs to effect a coordinated spectrum of care for local veterans.

Vet Center counselors are well-trained clinicians operating close to the veterans in the community and tailoring the services provided to the needs of the local veterans. The Vet Center program service mission features a holistic mix of direct counseling and multiple community-access functions: psychological counseling for veterans exposed to psychological war trauma, or who were sexually assaulted during military service, family counseling, community outreach and education, and extensive case management and referral activities. The latter activities include the full range of social and psychological services designed to assist veterans improve their quality of life and their level of social and economic functioning.

However, the lack of consistent employment services at the Vet Centers needs to be addressed by the VA and the U.S. Department of Labor. Given that neither Labor or VHA is seemingly prone to address this need (otherwise they would have addressed it long ago), Congress must reform the Department of Labor's Veterans Employment & Training Service grant programs to the states to make them much more accountable for results, and to ensure much collaboration with the Vet Centers as well as VA Vocational Rehabilitation & Education Service.

In the past two years, the Vet Centers have also acquired the additional function of providing education and counseling to veterans treated for HIV and hepatitis C at VA medical centers. The latter services also include assistance to veterans' family members. In addition, Vet Center community access functions are used to facilitate provision of VA primary care closer to veterans' communities through collocation and tele-health initiatives.

There has been no specific augmentation of Vet Center resources in over 10 years. Small annual incremental budget increases have enabled the program to meet inflationary increases and to maintain the same level of services over the years. With

no increase in program resources, the Vet Centers have, nonetheless, systematically extended the scope of their mission to include new veteran populations from the Gulf War; the peace-keeping missions in Somalia; Bosnia and Kosovo; World War II; the Korean War; as well as taking on the largest component of VHA's sexual-trauma counseling.

Through stringent cost saving approaches, the Vet Centers continue to be one of VA's most cost-effective programs. The Vet Centers have managed to remain cost-effective without sacrificing services to veterans; they have the highest rate of consumer satisfaction for any VA program. Additional FTEE and associated salary dollars for the Vet Centers will ensure the program's capacity to fully provide its unique service mission in those communities needing staff augmentation.

RCS currently has 206 Vet Centers and 941 FTEE. The operating budget for FY 2001 (minus field travel dollars and the contracts program budget) is $70.6 million. Vietnam Veterans of America urges that for FY 2002, the RCS Vet Centers be specifically authorized and appropriated an additional 60 FTEE, and be specifically accorded $3.8 million in additional funds, for a total of $74.4 million and 1,001 FTEE for FY 2002.

VETERANS BENEFITS ADMINISTRATION

In regard to the Veterans Benefits Administration (VBA) we recommend at least $80 million increase, with the proviso that increased attention be paid to the hiring and proper training of new adjudicators, ensuring that these new personnel are attuned to knowledgeably, accurately, and equitably adjudicate veterans claims in a timely manner, with presumption in favor of approving a substantiated claim. To train new personnel and to look for reasons to deny a claim, as opposed to working with veteran to identify evidence that supports the claim, is not acceptable.

Furthermore, the VBA needs to take significant meaningful steps toward holding their staff in particularly the supervisors and managers, on more accountable for the accuracy and quality of their work. As of now, the predominant measurement emphasis is on volume of processed veteran claims, irrespective of how well or accurately the decisions were made. Because veterans know this, the number of appeals and remands by the Court of Veterans Appeals and the Board of Veterans Appeals back to the Regional Office of the Veterans Benefits is very high.

Veterans have lost confidence in the system and appeal everything. The number of remands and regional office decisions overturned indicate that veterans are correct to have little faith in the fairness and accuracy of decisions in many regional offices. Moreover, the high remand rate on appeal is directly responsible for increasing the pending claims backlog at the regional offices. Returned claims are afforded expedited consideration, pushing new claims that have been languishing in piles even further down the docket.

If we are ever going to eliminate the backlog of claims, the focus has to be on doing it right the first time. A few years ago the Ford Motor Company almost went out of business because the emphasis on the production line was solely on speed and volume, and not on quality. Once Ford focused on getting it right the first time, production costs went down Ford survived and earned the trust of the American people.

The same sort or improvement in performance and results can also happen at the VA if Congress moves to assist Secretary Principi in this task. While at least $80 million more is required for VBA, VVA is equally concerned about performance and results. Vietnam Veterans of America is very concerned that the money that is being spent toward accomplishing the objectives set by Congress and the Secretary.

The National Cemetery Administration needs a significant increase to keep pace with inflation (at least $10 to $12 million). The Office of the Inspector General appropriation should be significantly increased, at the same time that Congress help refocus their mission. Too much time is being spent on recurring reviews that result in few changes or improvements of services to veterans. VA management needs to be held accountable for following through with decisive action.

Mr. Chairman, Vietnam Veterans of America urges you and your distinguished colleagues to push hard for a significant increase in the administration's request for the FY 2002 VA appropriation. VVA also urges that you push hard for safeguards to ensure accountability for actual performance and results in all areas of the VA.

VVA strenuously objects to the proposal to transfer $235 million from the Veterans Health Administration (VHA) to the Department of Defense (DoD) to help pay for the recently expanded Tri Care benefits. This is an outrageous suggestion, and we urge Congress to reject it out of hand. The Defense side of the budget has plenty of room under the cap to pay for these benefits that retirees have earned by virtue of longevity retirement. General Motors does not ask Medicare to pay part of the

"retiree benefits", nor should a resource-rich DoD ask an under-funded VA to pay their bills.

VVA also strongly urges you and your distinguished colleagues on this Committee to hold a series of oversight hearings this year focusing on what VA said they were going to do with both the money appropriated for FY 1999 and FY 2000. Since Congress gave significantly more funds than VA said they needed to accomplish the goals set forth in their submittal, the central question should be about results and performance.

Mr. Chairman, Vietnam Veterans of America thanks you for this opportunity to share our views on the budget for FY 2002 for the Veterans Administration. We stand ready to actively support you and your colleagues on this Committee in every way we can to achieve proper funding for vitally needed services and treatment of veterans, and to ensure that those funds are spent effectively to achieve the best performance.